Organizational Change: Implications of Culture and Leadership in the Transformation to a Total Quality Management Paradigm

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Abstract

The study was undertaken to investigate organizational readiness for change to a total quality management (TQM) paradigm as the corporate-wide strategy within a long-term care facility. The focus of the study was on leadership values and organizational cultural characteristics that could either accelerate or impede the change process at The Public Hospital. Structurally, the study included three distinct components. The first component examined the management philosophy outlined by Deming (1986) and his contemporary Juran (1989) in order to determine what leadership values best support the new Total Quality Management paradigm. Secondly, this information was compared to present leadership values at The Public Hospital with the purpose of identifying opportunities for improvement within the organization's current culture as the hospital moves toward the desired TQM culture. The final component, a roadmap, was developed to reflect the most appropriate direction for organizational change at The Public Hospital.

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CHAPTER ONE: THE PROBLEM

Introduction

The ultimate outcome for Quality Assurance (QA) programs within health care has been to produce observable, measurable improvements in patient care. Yet, for all the financial and human resources expended by hospitals, QA has fallen short of expectations (American Health Consultants, 1990; Wilson, 1992). The dilemma is two-fold. Not only have QA programs been unable to secure improved patient outcomes, they have also managed to generate a fair bit of animosity among hospital personnel. Both issues are rooted in the same basic problem: the present management approach of appraisal and inspection as the mainstay of quality assurance activities (Green,1991; Wilson, 1987). Inspection creates an uncomfortable working environment, encouraging a culture of blame and distrust (Berwick, Godfrey & Roessner, 1990; Deming, 1986). These two characteristics, according to Jones and Bearley (1986) are common behaviors within dysfunctional organizations. Berwick, Godfrey, and Roessner (1990) suggest that blaming as a dysfunctional response is the result of a sole focus on individual performance, whether that of the janitor or the cardiologist, in the absence of other influencing factors. They refer to this folly as tantamount to a "sort and shoot" mentality. Such a climate creates a kind of defensive posturing that can

lead to cover-ups, micro-management, finger pointing, and pervasive anxiety. A cycle of fear is set in motion, a situation that can be extremely destructive for the individual and the organization. Within this culture, quality cannot be produced or delivered.

Other inadequacies inherent in a quality assurance approach include: the attempt to address quality issues too late--after the service is complete, inattention to escalating quality costs while productivity declines, and adherence to a "fire-fighting" mentality, which place the organization in a perpetual state of reactive management. The truth is that not much can be done to improve quality until health care administrators understand how to manage effectively and what leadership in total quality management (Juran, 1989) with a commitment to continuous quality improvement (Deming, 1986) can offer their organizations (Grucic & O'Sullivan, 1991). This will require insight into why change is desirable, understanding of the theories and methodologies of total quality management, and a top level willingness to work for change.

Statement of the Problem

This study will clarify The Public Hospital's present leadership beliefs and values, and determine how these are upheld within the behavioral norms of the corporate

culture. In so doing, the study will assist the researcher in understanding the organization's readiness for change. Are the fundamental leadership values and behaviors at The Public Hospital capable of supporting the Board of Governor's decision to base corporate strategy on the principles and philosophy of total quality management?

Research Questions

Subsequent questions are:

1. What are the fundamental leadership values currently supporting the corporate culture and driving organizational performance?
2. How are those values expressed in behavioral norms?
3. Does the present cultural and behavioral make-up of the hospital support Deming's principles to:

    #1. Create constancy of purpose for improvement of product and service.

    #5. Find problems. It is management's job to work continually on improving the system.

    #8. Drive out fear so that everyone may work effectively for the company.

    #9. Break down barriers between departments.

    #12. Remove barriers that rob employees of their pride in workmanship.

(Gitlow & Gitlow, 1987, p. 20)

Background of the Problem

The Public Hospital, a long-term care facility in

south central Ontario, has worked diligently since 1987 to develop a quality assurance program that would satisfy external accreditors (i.e., Canadian Council on Health Facilities Accreditation (CCHFA) Standards), external regulators, the Public Hospitals Act, and fulfill the internal expectations of high quality patient care. For a chronic care and rehabilitation institution the issue of quality of care is especially salient as the facility provides a home for those hospitalized from a few months to as many as three or more years (in 1991 The Public's average length of stay was 152 days). Quality of patient life and quality of work life for those staff interacting with the same patients over extended periods of time are fundamental to satisfactory outcomes.

In October 1990, after three years of attempting to implement QA and finding themselves generally unhappy with the results of their efforts, The Public Hospital's Quality Management Committee recommended a change from the traditional QA approach in favor of "continuous quality improvement" (Deming, 1986; Juran, 1989). Through pilot studies held at The Public Hospital to test the appropriateness of the application of TQM in health care, through informal discussions with selected senior managers, and as an outcome of a presentation to the Board of Governor's Quality Assurance Committee, a recommendation from the staff Quality Management Committee

was accepted by the Board of Governors of The Public Hospital. The recommendation stated,

> That The (Public) Hospital Board of Governors and senior managers begin immediately to seek education in TQM/CQI so as to adopt and use the theories and methodologies of TQM/CQI as their corporate management strategy (Minutes of the meeting, Board of Governors, The Public Hospital, December 23, 1991).

Plesk (1990), suggests that three preconditions must be present to precipitate the change process: a tension for change, an awareness of alternatives, and confidence that change can happen. In the case of The Public Hospital, tension for change was generated by two major factors--a long-standing belief by the staff quality management committee that the existing QA program was not contributing to significant organizational improvement, and a failing health care economic environment attested to in a memo forwarded from the then Deputy Minister of Health, Ontario advising hospitals in Ontario that a deficit position was no longer acceptable. Ministry officials cautioned that deficit recovery plans were expected by December 6, 1991 from all hospitals projecting a fiscal deficit position for 1991/92 (see Appendix A). The Ministry of Health (MOH) directive of a 1% budget increase for 1992/93 and a 0.5% increase for 1993/94 aroused further anxiety in Ontario hospital administrators still reeling from a 29% wage increase endorsed by the Ontario Hospital Association for allocation to registered

nurses during 1991 contract negotiations.

The acceptance of the staff Quality Management Committee's recommendation by the Board of Governors demonstrated that an alternative to the current management approach had been recognized and endorsed. The next challenge would be to build confidence in the organization leadership's ability to change. The researcher, as the Director of Staff Development and Quality Management, had been given the task of building confidence while simultaneously coaching The Public Hospital's leadership through the planning and the implementation stages of the change.

The move into TQM constituted a paradigm shift that would challenge the very heart of The Public Hospital, its corporate culture. The adoption of a TQM philosophy meant a redirection of core corporate values from finance-driven mental models (quality follows cost) toward those that support quality-driven decision making (cost follows quality). It would be a challenging undertaking for The Public's leaders to commit to a long-range quality-based view of continuous improvement versus the short-term, quarterly-based quick fix approach (Kilmann, 1989). Essentially, the hospital Board and management team would be asked to abandon the quality assurance program in favor of a management system embracing continuous quality improvement. This change would require the use of data

collection activities, the creation of service models bent on customer satisfaction, the assessment of the utility of the hierarchical structure for decision-making and those political processes that support it, a reduction in bureaucratic controls by the introduction of processes to encourage employee self-control, the establishment of cross-functional and interhierarchical communication networks through teamwork (Grucic & O'Sullivan, 1991), the redressing of organizational goals in terms of quality planning, and visible advocacy for participative management. Moreover, the organization would need to establish a collective vision, blending idealism and realism, to inspire employees yet retain balance during the enormous internal pressures exerted throughout the transformative process.

Definition of Terms

Behavioral norms are those behaviors within an organizational culture that are acceptable and reinforced, "the result of a pattern of antecedents-behaviors-consequences." (Luthans & Thompson, 1990, p. 340)

Bureaucracy refers to the traditional hierarchical organizational model distinguished by controls, generally in the form of policy and procedures, and by unidirectional communication patterns. Within the bureaucracy, both controls and communication are top-down

in nature with very limited information flowing up the organizational hierarchy.

Bureaucratic governance which "makes use of organizational policies and procedures to shape employee behavior...where employees lack the professional competence to perform without being monitored, management may rely on policies and rules to govern behavior" (Lake & Ulrich, 1990, p. 182).

Business climate refers to the complex of social, economic, and political demands faced by The Public Hospital as it reflects on its own reality within the health care community. Because the focus for The Public Hospital is on long-term care and rehabilitation, customers, technologies, and government influences will differ from an acute care center. The demands of an aging and diverse patient population, pressures from reductions in public funding, and the integration of the Ministries of Health and Social Services in planning strategies for long-term care will influence the business climate in which The Public Hospital is able to carry out, with excellence, those activities pertinent to a long-term care setting. According to Deal and Kennedy (1982), "the business environment is the greatest influence in shaping a corporate culture" (p. 13).

Culture is described as "a set of cognitions shared by members of a social unit. These cognitions are

acquired through social learning and socialization processes that expose individuals to a variety of culture-bearing elements. These elements include the observable activities and interactions, communicated information, and material artifacts that form the social experience" (Rousseau, 1990, p. 154).

Cultural capability builds strategic unity which is fundamental to successful organizational transformation. It refers to the ability of organizational leaders to create a shared mindset, " a uniform way of thinking, perceiving, and valuing both the goals of an organization and the processes used to reach those goals" (Lake & Ulrich, 1990, p. 55).

Leadership capability applies to the leadership competencies necessary for diagnosing organizational problems and potentials and for managing change through flexible, responsive corporate structures, processes, and activities.

Leverage point is "anything that a manager can change in the organization, such as rules, procedures, objectives, and the acquisition of skills" (Kilmann, 1989, p. 12).

Mental models are "deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take action" (Senge, 1990, p. 8).

Organizational capability is "a business's ability to establish internal structures and processes that influence its members to create organization-specific competencies and thus enable the business to adapt to changing customer and strategic needs" (Lake & Ulrich, 1990, p. 40).

Total Quality Management is "a strategic, integrated management system for achieving customer satisfaction which involves all managers and employees and uses quantitative methods to continuously improve an organization's processes" (U.S. Federal Quality Institute, 1989 as cited in Hull, 1990). Total quality management, continuous quality improvement and quality improvement are interchangeable throughout the literature, although some experts in the field like Batalden (1992), Nolan (1992), and Senge (1992) are beginning to refine the distinctions among these labels.

Values are "the basic concepts and beliefs of an organization; as such they form the heart of the corporate culture" (Deal & Kennedy, 1982, p. 14).

Delimitations and Scope

The study was limited to the leadership, Board of Governors and the management team, senior and middle levels, of a 128-bed, chronic care and rehabilitation facility in an urban setting in south central Ontario. As a separate system within the continuum of health care in

its locale and in Ontario, the cultural climate of The Public is a unique blend of values, beliefs, and practices established over more than 80 years of history.

Outline of the Remainder of the Document

Throughout the literature review of Chapter Two, the reader will be acquainted with Quality Assurance (QA) and its fit within the formal organizational structure. The reader can also expect to better understand the complex of issues that have provoked a tension for change from QA to quality improvement within health care. The basics of Juran's (1989) and Deming's (1986) shared theory of continuous quality improvement will reveal an alternative approach selected by the Board of Governors of The Public Hospital and the challenges faced as the organization moves in the new direction.

Chapter Three outlines the methodology and instruments employed in the assessment of present leadership beliefs of The Public Hospital. Tools selected for measurement examine currently accepted leadership beliefs, managers' and Board members' perception of the ability of The Public to manage change effectively, and the explicit values contained within the hospital's Mission Statement and other public documents.

Chapter Four will provide a description of the outcome of the evaluation with a summary of the study

findings. Because the primary objective of the evaluation is to determine a roadmap for change to TQM, Chapter Five will present to the reader the strengths and weaknesses faced by The Public as a result of the beliefs and values of the management and Board of Governors, The Public Hospital's cultural capability for change, and recommendations outlining the roadmap for organizational change to TQM.

CHAPTER TWO: REVIEW OF RELATED LITERATURE

Historical Background

In 1985 the Canadian Council on Health Care Facility Accreditation (CCHFA) mandated that every accredited hospital in Canada develop a quality assurance (QA) program whose purpose would be to address the ever increasing cost of health care delivery and monitor the outcome of that expenditure. In essence, two questions were uppermost in the minds of hospital accreditors, regulators, and administrators: Are we doing things right? What is our outcome in both service and cost? The answer to these questions, it was hoped, would force hospitals into accepting accountability for service outcomes and cost of service provision inasmuch as hospital expenditures were accounting for at least 40% of the Canadian health budget (Kushner & Rachlis, 1989). Ontario alone was spending, and continues to spend, one third of the Provincial budget on health care, an annual amount in excess of $17 billion dollars (as reported in November 1991 in a speech at the District Health Council conference by M. K. Lindberg, Assistant Deputy Minister, Consumer Health, Ontario). Through quality assurance, it was believed that the Canadian tax-payer would be convinced that health care was offering good dollar value.

In Ontario, curriculum in QA theory and practice was developed under the guidance of the Ontario Hospital

Association and taught in virtually every Ontario Hospital interested in maintaining accreditation status. The training program was based on principles of adult learning and designed to fit the traditional formal organizational model (Wilson, 1987). Structure, process and outcome were the key elements of a QA program with the emphasis increasingly being placed on outcome (Green, 1991; Wilson, 1987).

Tension for Change

As QA programs matured, a new controversy arose. It became imperative not only to question if things were being done right (an outcome focus), but also whether the right things were being done (Deming, 1986; Drucker, 1985; Juran, 1989). For example, in the late 1980s, concern was growing over whether certain surgical interventions (e.g., coronary by-pass, Caesarian section, hysterectomy) needed to be performed at all. Studies of physician practice patterns confirmed wide regional variations (Fulton & Sutherland, 1988; Kushner & Rachlis, 1989). Typical hospital responses to rising costs and awareness of risk were the creation of two more departments in addition to the quality assurance department. Larger urban acute care hospitals such as Toronto Sunnybrook, Children's Hospital of Eastern Ontario in Ottawa, and the McMaster Medical Center in Hamilton were especially quick to establish

separate departments for quality assurance, risk and utilization management. This strategy only served to promote expansion of an already burdened bureaucracy. However, in October of 1991, the Ontario Ministry of Health informed all hospitals expecting a fiscal 1991/92 deficit to submit a deficit recovery plan by December 6th (see Appendix A). With a promise of a 1% increase in hospital-based funding for fiscal 1992/93 and later, a 0.5% increase for 1993/94, the Ministry of Health set into motion a tension for change unprecedented in health care in Ontario. If health care, like other industries, were to survive and remain competitive through "doing better with less" (Hull, 1990), then the manufacturing sector notion of change through quality improvement would need to permeate the entire hospital system--structure, process, and ultimately outcome.

Hierarchical Structures and Quality

Within a hierarchical structure, the organizational chart, as bureaucratic map, is purposeful for defining functional divisions within the company and for indicating reporting channels for responsibility and protocol. It would follow that management fixation with the formal structure could be, in large part, an impediment to the provision of quality. Organizational charts in fact represent "managerial cultural assumptions...[which]

dominate managerial thinking about strategy, structure, and systems" (Schein, 1986). The formal bureaucracy has historically encouraged "segmentalism ...[which] is concerned with compartmentalizing actions, events, and problems and keeping each piece isolated from the others" (Kanter, 1983, p. 28). Traditional quality assurance programs integrated well with the formal organizational model but they failed to unify organizational visions of quality and service excellence. QA programs were trapped within the segmentalism of the hierarchy which was itself incapable of producing quality outcomes. Many current authors (Aburdene & Naisbitt, 1985; Denlinger & Emshoff, 1991; Deming, 1986; Drucker, 1985; Juran, 1989; Kanter, 1983; Kilmann, 1989; Lake & Ulrich, 1991; Senge, 1990) have voiced an alternative to the hierarchical structure. They advocate the need for corporate restructuring, flattening senior level management, and problem solving in teams--a move away from reductionist management practices toward an organic, integrated approach.

Segmentalism and Change

Mental models held by traditional senior managers and hospital Boards have restricted clear understanding of the association among quality, productivity and cost. For years, health care has been finance-driven, believing that quality should follow cost. Subsequently, decision-making

based on the primacy of quality has proved to be an onerous task for health care administrators holding rigid financial mind-sets about how to manage. Quality assurance, considered by senior managers as abstract and without real cost-benefit merit, was delegated down the corporate ladder, and eventually subjugated to the good will of the individual department supervisor. As the assurance of quality assumed the role of an intradepartmental issue, subsystems were further optimized, cementing the segmentalist mentality. Essentially, quality problems, isolated and separated from the whole, have been solved independently and intradepartmentally. Indeed, for department managers to admit that their functional area could be influencing some other segment would be incomprehensible. However, to blame other departments or individuals for their problems proved quite acceptable (Kanter, 1983). Berwick (1989) and Berwick, Godfrey and Roessner (1990) refer to this aspect of traditional quality assurance as the search for "bad apples," an activity involving inspection against a predetermined set of standards which results in sorting the good from the bad. Consequently, energy squandered in territorial skirmishes has depleted vigor available for innovation, co-operation (Kaluzny, 1989), and change (Aburdene & Naisbitt, 1985; Argyris, 1990; DeVanna & Tichy, 1986; Denlinger & Emshoff, 1991; Kanter, 1983;

Senge, 1990).

> Companies where segmentalist approaches dominate find it difficult to innovate or to handle change. Change threatens to disturb the neat array of segments, and so changes are isolated in one segment and are not allowed to touch any others. In searching for the right compartment in which to isolate a problem, those operating segmentally are letting the past--the existing structure--dominate the future. The system is designed to protect against change, to protect against deviation from a pre-determined central thrust, and to ensure that individuals have sufficient awe and respect for this course to maintain their role in it without question--though they may fight over their share of the proceeds. (Kanter, 1983, p. 29)

Jones and Bearley (1987) support the notion of resistance to change, either overtly or passively, as characteristic of a dysfunctional organization. Other characteristics include blaming, finger-pointing and sabotage. Aburdene and Naisbitt (1985) believe that hierarchical structures contribute to organization dysfunction,

> The hierarchial structure where everyone has a superior and everyone has an inferior is corrupting of the human spirit--no matter how well it served us during the industrial period. (p. 41)

The formal organization continues to value an environment which demands finance-based results. Standards, objectives, and controls continue to be the mainstay of bureaucratic mental models that demand management by outcome. In fact, management by objectives or results is counterproductive (Joiner, 1988; Starcher, 1992).

In contrast, Scholtes (1988) supports Deming's (1986) vision of effective management as process directed,

> Management by results pays little, if any, attention to processes and systems: the real capabilities of the organization as a whole. So these standards and goals are nothing but arbitrary numerical goals. Eventually, workers, supervisors, and managers get caught up in games; looking good overshadows a concern for the organization's long term success. Too often, they lose sight of the larger purpose of the work they do. (Scholtes, 1988, p. 1-v)

Countable results receive top priority by managers and Board members who have discounted the value of quality in cost and productivity. In reality, desired numerical goals may be obtained but at the cost of worker morale and organizational culture. "When goals are met, the entire company can boast of its performance. But this attitude wreaks havoc with quality and worker morale along the way" (Scholtes, 1988, p. 1-vi). Management by results not only supports Berwick's (1989) theory of bad apples by perpetuating fear and anxiety but it also induces sabotage (Jones & Bearley, 1987) as employees attempt to circumvent the system rather than to engage in working toward improvement.

> This charade fosters guarded communication and minor, sometimes major dishonesty. The greater the stress on reaching unattainable goals, especially when someone's career is on the line, the more likely it is that reports and numbers will be given a face lift. (Scholtes, 1988, p. 1-7)

Most serious of all weaknesses built into hierarchical management is the blind eye turned toward

customer concerns (Berwick, 1989; Berwick, Godfrey, & Roessner, 1990; Joiner, 1988; Juran, 1989; Lake & Ulrich, 1990; Senge, 1990). Deming (1986) is careful to point out that customers are both internal and external to the organization. Many hospital mission statements and philosophies address quality of work life (internal customers) and quality of patient life (external customers), but with little understanding of the ingredients of such phrases.

Finally, a segmented organization can tolerate, and thus promote, only limited learning (Argyris, 1990; Kanter, 1983; Senge, 1990). Because, in the approach of traditional quality assurance, problem identification and solution has supported "single loop learning" (Argyris & Schon, 1978), continued adherence to quality assurance methodologies may be a key contributor to "organizational learning disabilities" (Senge, 1990, p. 18). Single loop learning is capable of only superficially addressing problems within an organization.

> Organizational learning involves the detection and correction of error. When the error detected and corrected permits the organization to carry on its present policies or achieve its present objectives, then that error-detection-and-correction process is single-loop learning. Single-loop learning is like a thermostat that learns when it is too hot or too cold and turns the heat on or off. The thermostat can perform this task because it can receive information (the temperature of the room) and take corrective action. (Argyris & Schon, 1978, pp. 2-3)

The Alternative

Genuine quality improvement requires that errors be detected and corrected in such a way that the organizational culture, structures and goals are modified to enhance the organizations' capability to provide service quality. Such organizational transformation requires "double-loop or reconstructive learning" (Argyris & Schon, 1978; Friedlander, 1983, as cited in Conway, 1985).

> In reconstructive learning the organization questions its premises, purposes, values. For individuals these are represented in one's goals, principals, life-style, beliefs. For the organization they are represented by its goals, policies, and norms... Reconstructive learning calls for in-depth confrontation of old patterns and the development of radically different new ones. It suggests the construction of new goals, policies, norms, styles rather than simple modification of the old. (Friedlander as cited in Conway, 1985, p. 10)

When formal bureaucratic structures are abandoned and team problem solving initiated, double-loop learning is possible. It is the team's job to search for root causes within systems that include interrelationships, patterns of change, processes within processes, as well as linear cause and effect. Ultimately, work life is made richer by helping workers and managers see together the deeper patterns and meanings behind events and details (Argyris, 1990; Denlinger & Emshoff, 1991; DeVanna & Tichy, 1986; Morris, 1987; Scholtes, 1988; Senge, 1990).

Because teams are held accountable to effect and

monitor the changes recommended from their problem analyses (Juran, 1989), they directly experience the consequences of their decisions and gain an understanding of a ripple effect throughout the organization that may last for years (Senge, 1990). Analysis and decision-making are seen as important and team outcomes are owned by the particular project team. Senge (1990) believes that along with systems thinking, personal mastery, mental models, and building shared vision, team learning is one of the five essential components of effective organizations.

> When teams are truly learning, not only are they producing extraordinary results but the individuals are growing more rapidly than could have occurred otherwise. ...Team learning is vital because teams, not individuals, are the fundamental learning unit in modern organizations. This is where the rubber meets the road; unless teams can learn, the organization cannot learn. (Senge, 1990, p. 10)

Kilmann (1989) concurs that to appreciate the complexity and interconnectedness of organizations there is a need to view them from a three-dimensional perspective. He refers to the organization as a "complex hologram," far beyond the scope of understanding it as either a simple machine or as an open system.

> Organizations must be viewed as holographic images. Otherwise, managers, consultants and academics will see only a small portion of the total picture... Without the holographic view, most of what goes on and must be managed for success would be beyond everyone's perceptual reach. (Kilmann, 1989, pp. 9-10).

Such a dynamic view of organizations would encourage multiple approaches and varied inputs for successful decision-making.

Deming (1986), a leader in the modern day industrial quality transformation, has outlined such a management strategy, the nucleus of which contains 14 points detailing his theory of continuous quality improvement (see Appendix B). Central to his and Juran's (1989) total quality management (TQM) paradigm are two important requirements for the continuous improvement of quality whether in products or services--an organization must develop a common constancy of purpose aimed squarely at customer satisfaction and must use teamwork and statistical tools to measure, monitor, and improve work processes (Deming, 1986; Denlinger & Emshoff, 1991; Gitlow & Gitlow, 1987; Juran, 1989). Unlike quality circles, quality improvement teams are cross-functional and interhierarchical in nature (Deming, 1986; Juran, 1989). Within such an arrangement workers and managers collaborate to take advantage of organizational opportunities for improvement. Team membership is organized around the process issue under investigation, spanning the entire process to include those working up-stream and down-stream. As process questions are revealed and knowledge evolves, team membership may be reorganized. In this way, team arrangements and the problem-solving

process remain fluid and adaptable. Teamwork itself is task oriented, using data collection methods and statistical tools for data analysis (Deming, 1986; Gitlow & Gitlow, 1987; Gitlow, Gitlow, Oppenheim & Oppenheim, 1989; Juran, 1989; Walton, 1986). The integration of qualitative and quantitative problem analysis forces the organizational system into a transactional experience, organic in nature. To elect an organic approach to management is to choose empowerment for the employee: "The world is actualized by our investigation of it. Knowing is an interactive process between the knower and the known" (Salz, 1990, p. 393).

Kilmann (1989), like his contemporaries, strongly supports participative management practices and teamwork; however, he advocates that effective teamwork, the pooling of process knowledge and worker expertise to get results, is impossible in the absence of a supportive organizational culture. Therefore, it is his contention that any successful change begins with attention to the organization's culture and the values, assumptions, and psyche that are its mainstay.

> Every organization has an invisible quality --a certain style, a way of doing things--that ultimately determines whether success will be achieved. Ironically, what cannot be seen or touched may be more powerful than the dictates of any one person or any formally documented system. To understand the soul of the organization, therefore, requires that we travel below the charts, rule books, machines, and buildings into

> the underground world of corporate culture. (Kilmann, 1989, p. 49-50)

Although quality assurance has not been the panacea previously expected for health care (Berwick, Godfrey & Roessner, 1990; Laffel, 1990; Wilson, 1992), the drive for service quality continues. Rapidly escalating costs, increased consumer dissatisfaction, rising litigation and compensatory claims, wide variation in practice patterns, and government redistribution of funding are pressuring health care organizations toward change (Berwick, Godfrey & Roessner 1990; Kushner & Rachlis, 1989; Snedden, 1987). Evidence of the commitment for systemic modification is the recent decision by the Ontario Ministry of Health to adopt the management methodologies of Deming (1986) and Juran (1989) into their organizational structures and processes. In addition, CCHFA has assembled a task force to address the issue of how to incorporate Deming's theory of continuous quality improvement (CQI) into their standards for 1993. The direction for The Public Hospital had been set by the Board--to adopt management practices reflective of a continuous quality improvement paradigm and aligned with the example being set by the Ministry of Health and CCHFA. However, before mobilization for corporate change could take place, the question of the organization's leadership and cultural capability to change needed to be addressed.

The Organizational Context

The Public Hospital was built on the present site in 1926 as a sanatorium for consumptive (tuberculosis) patients. Throughout its history, it has served as a sanatorium, an acute care facility, a hospital for chest diseases and, since 1975, a chronic care and in-house rehabilitation center. As such, The Public Hospital is the only free-standing chronic care and in-house rehabilitation facility in its Region. Therefore, the chronic care catchment area from which the hospital could draw is approximately 55,296. This number represents the estimated number of people over the age of 65 years, a 19.4% increase of people over the age of 65 years since 1986 (Statistics Canada 1991 figures, as cited in Jodoin, 1992). The catchment area for rehabilitation services, taking account of the entire population of the Region, approximately 370,000, is much broader. Because of its specialized services, The Public Hospital has enjoyed a niche within the health care market--a situation that has allowed the hospital to acquire specialty status within its community and to have established a long and honored tradition in the delivery of care and service.

Presently, the hospital has a chronic care population capacity for 102 patients and a 22-bed in-house rehabilitation unit. Hospital staff treat primarily older chronic patients (65 years of age and older) although

younger adults with chronic conditions are also admitted. The rehabilitation population consists of a mix of adult age groups whose presenting problems may include amputations, cerebral vascular accidents and fractures (Jodoin, 1992). Programs offered to achieve and maintain optimal functional levels, comfort and independence for chronic care patients include palliative care, respite care, slow-paced rehabilitation, and intervention strategies for chronic obstructive lung disease and tuberculosis. In the past two to three years, there has been an increase in a younger chronic care population of patients suffering from multiple sclerosis. A community outreach program specific to multiple sclerosis has been designed to provide therapeutic and supportive assistance to caregivers and patients from the hospital and the community.

The medical manpower of The Public is accounted for by six physicians, one of whom is a Medical Director who also operates the hospital's outpatient clinic. The Medical Director attends annually to approximately 3,500 (1991-92 figures) visits for patients with respiratory related diseases. An on-site physician regularly attends to chronic care patients, and four consulting physicians, externally contracted, assist in meeting the needs of both chronic and rehabilitative patients.

The Chief Executive Officer (CEO)/ Executive Director

(ED) and four Assistant Executive Directors (AEDs)--Patient Care, Hospital and Paramedical Services, Finance, and Human Resources--assist the CEO on the senior management team. Reporting to this group are 19 department managers, who together comprise the middle management team. Because of this reporting structure, the Public Hospital's managerial hierarchy is considered quite flat.

Employee complement fluctuates at approximately 300 employees, both full- and part-time. The Nursing Department accounts for the largest number of employees, approximately 165. Dietary Department and Housekeeping are the next largest.

According to the Ontario Hospital Association, the Board of Governors is accountable to "establish the mission and nature of the hospital" (as cited in Wilson, 1988, p. 8). There are 27 members of the Board of Governors at The Public Hospital, 18 voting and seven ex-officio members. The two remaining have been appointed Honorary Life Governors and are inactive members.

A Patient Advisory Council was established in 1990 to provide a forum wherein issues important to patient institutional-related lifestyle preferences could be heard. At the time of its inception, dissatisfaction with the quality of care was brought to the attention of the CEO. Out of this dialogue, the senior management team and

the Board solicited the research skills of a psychologist, Dr. K. Belicki, to undertake a quality of patient life study. Over the course of two years, this study broadened to include quality of worklife from the frontline and department manager perspective. The survey report became available November 25, 1992 to all who had participated in the process. Some of the findings have been incorporated as supportive information for this study.

In addition to paid staff, The Public Hospital has approximately 25 volunteers who assist in patient feeding, personal care, outings, recreation and leisure activities. A glance at the organizational chart graphically depicts the reporting structures throughout the Public (see Appendix C).

The Business Climate

The services offered by The Public Hospital are part of a continuum of care throughout the Region. For the past two years, The Public Hospital has been engaged in the planning process for an addition to house 52 beds and a chronic care Day Hospital Program to accommodate 25 patients daily. In order to accomplish this, the Public Hospital Board of Governors and senior management team have initiated a process to involve local providers in the planning. Additionally, the hospital leadership solicited the services of a local consultant to up-date the hospital

on geriatric service needs by evaluating current issues with the intention of better understanding future program requirements.

Current Long-Term-Care planning for the city in which the hospital is situated is proceeding with the assumption that all future chronic care services will be consolidated at The Public Hospital with appropriate linkages established with acute care centers and home care programs (Jodoin, 1992).

The hospital receives operational dollars from the Ministry of Health, Ontario. Any approved capital projects are funded 60% by the Ministry of Health and 40% by the facility. The annual operating budget is approximately $12,000,000.00. Fiscal 1992-93 saw a 2% increase from the Ministry of Health while 1993-94 has been held at 0.5%. The senior management team voluntarily froze their salaries in 1992-93 to be better able to meet financial demands. The greatest financial pressure is salaries, in particular those agreed to by the Ontario Nurses' Association and the Ontario Hospital Association. The agreement took effect prior to the announcement in 1991 of the limited funding base (2.0%) forthcoming from the Ministry. The other employee union at The Public Hospital is the Canadian Union of Public Employees.

CHAPTER THREE: METHODOLOGY AND PROCEDURES

Design of the Study

Culture, when viewed as a psychological process of perception as well as a social construct, becomes an enormous concept to unravel. For the purpose of the study, as a descriptive survey, the collection of data was narrowed to the examination of corporate values. The Mission Statement and the Statement of Philosophy were used for their artifact importance. Other sources for values analysis included patterns of decision-making and communication and styles of interpersonal relationships, all of which could be determined through organizational behavioral norms principally articulated by the actions of the Chief Executive Officer (CEO) and the senior management team. In addition, members of the Board of Governors, as leaders and providers of organizational direction and purpose, were assessed to indicate whether their vision for The Public Hospital was that generally shared by members of the hospital management team. In viewing each of these origins of corporate values, the researcher was able to move from the periphery of the organization, the study of artifacts, through to the more difficult to assess area of fundamental assumptions that support behavioral norms and constitute corporate values (Kilmann, 1989; Rousseau, 1990).

Given the variety of personal, collective,

hierarchical, and sub-cultural configurations possible within the society of the organization, organizational culture research can be viewed from many competing perspectives. Therefore, for the purpose of this study, it was important to consider both the personal and collective level of analysis. Neither quantitative nor qualitative research alone is sufficient for the task of describing an organization's culture (Dansereau & Alutto, 1990; Rousseau, 1990). Thus, the study was designed in four separate phases and used quantitative surveys, an evaluation of artifacts, qualitative interviews, and group discussion. Although the activities within each phase are the primary sources of information, the researcher's personal observations over the course of six years as a department manager and educator at The Public Hospital also proved a valued origin for understanding the social environment.

Phase One

In the first phase, Department Managers, Senior Managers and Board members were requested to complete three questionnaires (see Appendix F). The purpose of the questionnaires was to describe the collective perception of managers and Board members particular to their perception of currently existing restraining and driving forces for change, to develop a composite description of

organizational reaction to change and to survey current knowledge about Total Quality Management within the management team and Board members.

Instrumentation

The choice of survey instruments had to meet two important criteria. First, from the organization's perspective, the tools needed to be simple to use and to interpret. Because the organization's purpose was to establish a baseline by which to measure organizational knowledge about TQM as well as cultural progress in the application of TQM, tool simplicity and facility were important considerations. Secondly, the instruments had to achieve the aim of the broader context of the research question: to identify organizational characteristics indicative of readiness for change in management practice, and to determine probable staff reaction to the adoption of a new theoretical framework for managers.

The Quality Improvement Audit for Leaders created by Brewer (1990) and based on Deming's (1986) model of continuous quality improvement, is comprised of a 100-item, true-false audit in which six dimensions of quality improvement are tapped: (a) leader's attitudes and beliefs, (b) leader's knowledge, (c) employee involvement, (d) use of data, (e) commitment to quality improvement,

and (f) personal leadership style. The tool was selected because of its potential to assess personal and organizational TQM knowledge and behaviors. To honestly appraise the current level of TQM knowledge and behaviors, respondents were asked to answer based on what is, rather than what should be. The purpose for selection of the Quality Improvement Audit for Leaders was to indicate, for the researcher, gaps in managers' and Board members' present knowledge and beliefs relevant to a quality-focused organization, and to assess whether prior exposure to TQM theory played a role in shaping attitudes and beliefs about a quality-focused management paradigm as defined by Deming (1986).

Brewer (1992) describes the instrument as "criterion referenced, each item having been validated according to research with 27 pieces of research materials including Deming" (personal communication, January 1993). According to Brewer (1992), the Quality Improvement Audit for Leaders has recently been tested at the University of Miami where it is reported to have performed very well, although no psychometrics were available.

The Organizational Change Readiness Survey (OCRS) and Organizational Change Orientation Scale (OCOS) (Jones & Bearley, 1986) assist organizations to evaluate total systems readiness and the systemic reaction to change. The OCRS is a 76-item survey tool. The items are

classified into five categories: (a) structural readiness, having the capability to reorganize readily in response to external pressures, (b) technological readiness, having the ability to remain current and open to innovation, (c) climatic readiness, having a supportive atmosphere, (d) systemic readiness, having systems in place to facilitate change, and (e) people readiness, having people who work well together and who can tolerate ambiguity. Individual responses to change are measured through the OCOS, a 36-item scale. Possible responses are classified as (a) functional, (b) non-functional, and (c) dysfunctional.

Little data exists on the internal reliability of either instrument, although the authors continue to collect data on the instruments' performance (Russo, 1992). Russo (1992) has described the OCOS and the OCRS as instruments developed by Jones and Bearley (1986) for the purpose of organizational training. As such, the instruments chosen were appropriate for use within the context of a descriptive survey of The Public Hospital wherein shared perception was fundamental to the qualitative portion of the study. In addition, two other important factors were considered--ease of use, and the potential to graphically depict a baseline of current organizational readiness, and reaction to change. The same surveys applied three to five years hence would be familiar; thus, accessible and acceptable for

organizational re-evaluation.

Each of the surveys used has been "quantified according to the rules of statistical analysis" (HRD Quarterly, 1991, summer, p. 1) and as such was considered to be valid and reliable for use in a descriptive survey of a single organization.

Sample and Population

Twenty-two staff--the CEO, four senior and 17 department managers, and nine Board members completed the surveys. This represents 89.5% of the management population and 50.0% of the Board of Governors. The remaining 10.5% of the manager group is accounted for by one individual, absent at the time of questionnaire completion, and the researcher.

Data Collection

Each manager was provided with a letter of purpose for the study (Appendix D) and asked to read, sign, and date the letter to indicate their agreement to participate. The managers completed their questionnaires as part of a department heads' meeting, for which the CEO had provided the time. Although the researcher planned to keep survey results of both managerial levels and the

Board separate, this did not prove to be possible. Because all managers, senior and departmental, requested assurance that there would be no way to identify individual participants, the opportunity to separate senior from department manager responses was lost. However, any participant who had received prior education about the theory and philosophy of Total Quality Management was requested to indicate so by making a check mark on the outside of his/her questionnaire. Eighteen active Board members were sent a package of the three questionnaires with an accompanying letter via a mail-out (Appendix E). Agreement to participate was obvious by the returned questionnaires. Nine (50.0%) completed packages were returned.

Data Analysis

Analysis of respondents' scores on the Quality Improvement Audit for Leaders was based on the aggregate scores of two independent groups, managers and Board members. In addition, respondents' scores were grouped by their TQM knowledge based on whether the respondent had received previous exposure to the concepts of total quality management. Analysis of variance was employed to determine differences in group responses by dependent variables, organizational level, managers and Board

members, as well as by knowledge, prior exposure to TQM information and no prior exposure. Likewise, the OCOS and OCRS scores were aggregated into group scores then examined according to level and knowledge.

The OCRS aggregated scores for each group, managers and Board members, were plotted separately on a force field chart (Jones & Bearley, 1986; Spier, 1973) for visual analysis and comparison. With both the OCRS and the OCOS, surveying at the personal level followed by aggregating scores at the collective level provided a clearer understanding of personal perception (between subjects) and collective perception (within groups).

The range in variation of individual reports about personal reaction to change and in collective perceptions about organizational change readiness provided a common platform to begin the qualitative component of the study. In addition to the quantitative data, the interview phase was made richer by the use of the hospital's most relevant artifact, the Mission Statement.

Phase Two

The written Mission Statement makes the organizational purpose, vision, and values explicit (see Appendix G). Phase Two consisted of an examination of the hospital's most recent Mission Statement and of a periodical commissioned by the hospital's Board of

Governors and published during the course of the study, The [Public] Hospital: Contributing to the Community's Continuing Care Needs.

Data Analysis

The method for analysis of the Mission Statement and a recent publication, The [Public] Hospital: Contributing to the Community's Continuing Care Needs, involved a review of the documents to clarify the stated purpose of the hospital, and the values by which the hospital defines itself in the execution of its stated purpose.

Phase Three

Phase Three consisted of loosely structured interviews conducted to acquire information about each Department Manager's and each Board member's agreement or disagreement with the questionnaire results. As well, the interviews provided a mechanism to share the collective perceptions of each group, Department Management and Board. Each participant was asked to comment on the force field analysis of his/her own and that of the other group, in particular to develop a hypothesis for similarities or differences in the aggregated score pattern. In addition, each Department Manager was requested to describe his/her experience of The Public Hospital's organizational culture

and patterns of social relationships. The Department Managers were asked, based in their own perception, to reveal what they believed to be the organization's behavioral norms. In contrast, because Board members are not involved in the day-to-day operations of the hospital, but through governance have a leadership role, they were interviewed about their vision for and understanding of the future direction of The Public Hospital. Examples of the question lines are provided in Appendix H.

Sample and Population

Daniel (1992) and Wilson, O'Hare, and Shipper (1990, as cited in Daniel, 1992) found that subordinates are better able to assess how supervisors get results than are supervisors themselves, whether through self-assessment or through performance appraisal mechanisms. Because the fundamental values and beliefs of The Public Hospital's leadership, the CEO, and the four Assistant Executive Directors, were the focus of the study, these individuals were excluded from the interview process. Instead, the study focused on the senior managers' values and beliefs as described by their subordinates, the recipients of both the words and the deeds of the senior management team.

Inasmuch as Board members are distant from daily management while having the authority and responsibility

to set direction for the hospital and to oversee the fulfillment of its mission, they were included in the interview phase.

Data Collection

Department Managers were interviewed at their convenience on site, and Board members either at their home or a place of their choosing. All 18 Department Managers were interviewed. Four Board members, those currently holding roles of leadership and influence at the Board level, were approached for an interview. These four included the Past Chairman, Present Chairman, Vice-Chairman, and the Chairman of Public Relations (Appendix H). Three of these individuals consented. With subject's consent, all interviews were recorded. If subjects expressed discomfort about being recorded, notes were taken during the interview. Only two subjects (9.5%) indicated a discomfort. All subjects were assured that individual audits, scales, and personal comments made within and outside the research processes would be kept in strict confidence by the researcher and that the results of the study would be presented as a composite of all subject contributions with no subject-specific attributions or observations. The use of direct quotes within the text of the research was done in a manner that

protects subject anonymity.

Data Analysis

All tape-recorded interviews were transcribed verbatim. The transcribed text was coded along with the interview notes from subjects who refused taping. Coding categories included organizational purpose and direction, desired image, futuristic thinking, organizational leadership style, reward and recognition, behavioral norms, rituals and celebrations, and heroes. As the process of sorting subjects' comments unfolded, five common themes began to surface into more specific groupings: shared vision and mission, organizational learning, empowerment, reward and recognition, and leadership and behavioral norms. Because the researcher chose to allow data to evolve throughout the interview process, some issues such as gender bias were included within the interview process only after two subjects had voluntarily raised the issue. In view of the importance of the finding, those individuals who had not been previously asked about their perception of a gender bias were surveyed at a later date. Inasmuch as the study was evolutionary, it was not always possible to establish actual respondent frequencies concerning all categories. However, part way through the Department Manager interview phase, it became clear that saturation had been reached on questions particular to mission, leadership, implicit and

explicit values, behavioral norms, reward and recognition.

Phase Four

Finally, Phase Four was designed to confirm perceptions and attributions verbalized by the Department Managers during their interview process. This was accomplished within the context of a teaching session designed to encourage learners to reflect upon individual and collective values. Within the context of learning about organizational culture as a social construct, explicit values and beliefs contained within the hospital's written Mission Statement were identified and compared to implicit values expressed in behavioral norms generated from within the group of learners, thus making the implicit generally explicit.

Sample and Population

In early October 1992, formal education in Total Quality Management began for 16 Department Managers (the remaining two had been requested to participate in the senior manager education program that had begun three weeks earlier).

Data Collection

The program consisted of ten sessions, each three hours in length. Two sessions were presented each Friday over a five-week period. The entire learning experience was based on principles of adult learning, and used an experiential model. To expand their awareness of systems thinking and organizational interconnectedness, Department Managers were assigned to teams in such a way that they would be working with colleagues with whom they would not normally interact.

The teams were taught tools for teamwork (e.g., nominal group technique, multivoting, consensus building) and were expected to use these skills throughout the instructional program. The final day was designed to enhance the learners' understanding about corporate culture, values and behavioral norms. The topic was framed to allow for team participation in the identification of explicit values. Each team dissected the hospital Mission Statement, identified values contained therein, and prepared a list of the values. All teams were then debriefed by having the researcher retrieve and collect the list on a flip chart. The next step was to have learners, still working within their teams, identify ways in which the values were behaviorally demonstrated by themselves and others in daily work. Conversely, they were asked to share stories of incidents

in which the values may have been compromised. Next, teams addressed their belief about the success of The Public Hospital in upholding its documented mission, vision, and values. The fundamental question put to the group was whether The Public Hospital visibly demonstrated who it professed to be. The instructor then asked participants if, based on their discussions, they believed The Public Hospital was ready to move into a TQM paradigm. If yes, what were the strengths and if no, why not?

For research purposes, this educational session presented an opportunity to check the validity of the interview process. Public disclosure of constructs discovered during confidential interviews would confirm the pervasiveness and mutuality of assumptions about shared vision and values, organizational learning, teamwork and empowerment, reward and recognition, and leadership. It was reasoned that if Department Managers would be willing to disclose their anxieties and frustrations publicly, the behavioral norms could be openly revealed and the issue of communal fear in the workplace could be examined.

Data Analysis

Finally, analysis of the group discussion phase of the research involved determining how many of the

Department Managers would engage in a team discussion about The Public Hospital's implicit and explicit values as barriers to organizational change. The next level of analysis examined how many Department Managers would engage in the broader, open-group exercise to reveal the same implicit and explicit values. Whether or not Department Managers openly revealed the same information concerning behavioral norms in the public setting as they had in the interview process would confirm the conviction of their privately stated perceptions.

Strengths and Limitations

The overall strength of the design of the study was its multidimensional nature that moved from the periphery to the core schemata of the organization and its leadership. The design also helped the researcher to understand the genesis of The Public Hospital, how it came to be what it is, and the cultural dynamics that continue to support it (Argyris, 1960). Table 1 breaks out, more comprehensively, the strengths and limitations of the overall study design.

Table 1

Strengths and Limitations of Study Design

Phase	Limitation(s)	Strengths
Phase One Quantitative Data Collection	Instruments, OCOS and OCRS have limited applicability across organizations. The context in which the surveys were completed did not allow managers real choice in a decision to take part. The return rate for the Board Group was disappointing (50%). Not all items were completed.	Instruments were suitable to describe of a single organization. Surveying at the individual and compiling information into a composite picture provided a way to speak to a profile of change for the hospital. The questionnaire component expedited the interview process.
Phase Two Artifacts Review	Due to time, the review was limited to only two sources of documented values.	The artifacts chosen did represent the most explicit sources of organizational values for the information of employees and the community at large.

(Table continues)

(Table continued)

Phase	Limitation(s)	Strengths
Phase Three		
Qualitative Interview	The researcher as a Department Manager has strong ties with that Management peer group. It required constant vigilance to remain objective during interviews, especially with friends. Co-worker trust and fear to speak up may have biased some responses. Board members may have been reluctant to speak frankly with a subordinate. Questions about senior managers' and the CEO's leadership performance was a delicate issue for the Board to share with a subordinate. This may have created a communication barrier during their interviews.	The groups interviewed were more likely to speak to the shared vision, behavioral norms, and leadership beliefs. Showed how two separate parts of the hospital relate to each other and to the whole.

(Table continues)

(Table continued)

Phase	Limitation(s)	Strengths
Phase Four		
Group Discussion	Teamwork may have prompted some to respond in socially acceptable ways.	Researcher could verify findings of interview process. Demonstrated whether the norm, "don't speak up" was operative among the Department Managers as a group. Provided information about fear in the workplace (i.e., to whom the Department Managers would express their dissatis-faction).
Researcher observations	The ever-present potential for bias as a stakeholder within the system. Researcher's own fear of findings and the reporting of the outcome due to risk of revealing the implicit values and behavioral norms.	As a stakeholder the researcher has past and continued experience with the environment. Familiarity with the organizational issues helped frame the study.

Undertaking a cultural study of one's own workplace presented a challenge for the researcher. It was impossible to avoid partiality. However, it was believed that the breadth and multidimensional design of the study compensated, somewhat, for the researcher's own organizational biases.

CHAPTER FOUR: RESULTS

For the convenience of the reader and ease of presentation, the following results have been separated into each of the four phases that comprised the study design: Phase One, questionnaire results; Phase Two, artifacts; Phase Three, interviews; and Phase Four, group discussion.

Phase One: Questionnaire Findings

The Quality Improvement Audit for Leaders was employed to determine The Public Hospital leadership's current knowledge about Total Quality Management concepts. Leaders were grouped by level, either management or Board membership, and by prior exposure to TQM theory. One audit from a Board member was returned incomplete. Therefore, eight responses from the Board and 22 from the managerial level were analysed. Significant differences in responses between the two organizational levels surveyed occurred on only one variable in the Quality Improvement Audit for Leaders--Commitment to Quality Improvement. Analysis of variance showed that managers as a group scored significantly lower on their reports of commitment than did the nine Board members who returned surveys. Table 2 provides a summary of the findings.

Seventeen of all 30 subjects (56.7%) reported prior exposure to TQM, whether formal through the Board of Governor's and senior management seminar in April 1992 or

Table 2

Mean Rating for Subjects' Reported Commitment to Quality Improvement

	Commitment to Quality Improvement			
Responses	M	SD	df	F
For Entire Population	6.35	2.52	(1,29)	5.37*
Manager Group	5.73	2.43		
Board members**	7.89	2.15		

* p. <.05

informal, through reading, discussions, membership on the Quality Management Committee, etc. Analysis of variance showed that previous exposure to the theory of Total Quality Management proved to be an important variable in how respondents answered the Quality Improvement for Leaders Audit sections on Attitudes and Beliefs about Quality, and Quality Improvement Principles. Table 3 shows the distribution of subjects' responses over both dependent variables.

Point biserial correlation was used to analyse subjects' prior exposure to TQM concepts with their responses to each section in the Quality Improvement Audit for Leaders. Prior exposure to TQM theory was moderately and positively related to Attitudes and Beliefs about Quality and Commitment to Quality Improvement, r pt bis = +0.57 and r pt bis = +0.60, respectively. This finding indicates a relationship between subjects' prior exposure to TQM theory and their scores on the audit sections concerning knowledge about and commitment to basic quality improvement concepts. Seven of 17 subjects with prior TQM exposure (77.8%) were Board members, and ten (45.4%) were from management. Because Board members had an opportunity for structured education at their April 1992 seminar on TQM, the context of the prior exposure may have been one important factor associated with participants' scores on quality attitudes and beliefs, and

Table 3

Mean Ratings for Subjects' Reports on Attitudes and Belief about Quality and Quality Improvement Principles

		Attitudes & Beliefs	
Subjects' Response	Population (N = 30)	Prior Exposure (N = 17)	No Prior Exposure (N = 13)
M	13.74	15.06	12.14
SD	2.60	1.68	2.68
df	(1,29)		
F	13.653**		

		Quality Improvement Principles	
M	15.71	16.65	14.57
SD	1.68	2.15	1.55
df	(1,29)		
F	9.108**		

** *p*. <.01

commitment.

Pearson correlational analysis showed that subjects' responses to Attitudes and Beliefs About Quality were directly related to their scores on Quality Improvement Principles. Commitment to Quality Improvement was positively correlated with both the Use of Data and Involving Employees. A summary of participants' responses has been provided within a correlational matrix in Table 4.

The Organizational Change Orientation Scale (OCOS), the inventory used to assist in the understanding about manager and Board member behaviors in change situations, showed no statistically significant differences in the aggregate responses of each of the two groups on predominantly functional, non-functional, or dysfunctional reactions to change. However, dysfunctional responses approached levels of significance. This may indicate a slightly greater inclination toward dysfunctional reactions to change situations within the management group (see Table 5).

Because of this finding, further analysis was undertaken to determine in which survey statements differences might be arising. The analysis revealed that responses to the statement, "I do not get involved significantly in organizational changes" were statistically different between the Board and management

Table 4

Correlations Between Responses on the Quality Improvement Audit for Leaders

	Measures					
Measures	A	B	C	D	E	F
A	-					
B	.4207*	-				
C	-.0974	-.1726	-			
D	.1918	.0407	.2983	-		
E	.2575	.1734	.5528*	.6261**	-	
F	.0326	-.2384	.2679	.2045	.2762	-

Note. A = Attitudes and Beliefs about Quality Improvement
B = Quality Improvement Principles
C = Involving Employees
D = Use of Data
E = Commitment to Quality Improvement
F = Personal Leadership Style

* p. <.01, one-tailed, **p. <.001, one-tailed

Table 5

Mean Ratings for Subjects' Reports on Dysfunctional Behavioral Responses to Change Situations

Subjects' Reports	Dysfunctional Behavioral Responses			
	M	SD	df	F
Entire Population	26.55	6.84	(1,27)	3.67
Management group	27.86	6.96		
Board members	22.43	4.79		

p. = .066

groups. As well, two additional statements showed differences, "I hide my opposition to organizational change," and "My response to organizational change is to ask, What's in it for me?" Table 6 presents a summary of the overall findings.

Analysis of variance in responses to the Organizational Change Readiness Survey showed statistically significant differences in the perceptions of the management group and the Board of Governors on both barriers to and supports for change. However, only one survey category reached a level of statistical significance in terms of barriers to change. People Readiness was perceived as a barrier by the management group (see Table 7). Collectively, the management group perceived that organizational ineffectiveness exists in "having managers and workers who can work productively together within an environment that is ambiguous and in flux" (Jones & Bearley, 1986, p. 5).

All survey categories in the supports for organizational readiness responses showed statistically significant differences in how the management group and Board members perceived organizational ability to manage change effectively. Board members were far more optimistic in their belief that the organization is ready to move satisfactorily into a new management paradigm. Analysis of variance, as seen in Table 8, shows

Table 6

Mean Ratings for Subjects' Reports on Specific Statements Concerning Behavioral Responses to Change Situations

Survey Item	Management Group		Board Members			
	M	SD	M	SD	df	F
Get involved in change	2.52	1.37	3.86	1.68	(1,26)	4.49*
Hide opposition	2.76	1.51	1.42	.54	(1,26)	5.11*
What's in it for me?	2.73	1.32	1.57	1.13	(1,27)	4.34*

* $p.<.05$

Table 7

Mean Rating for Subjects' Reports on Perceived Barriers to Organizational Change Readiness

Survey Item	Management Group M	SD	Board Members M	SD	df	F
People Readiness	3.50	3.58	.78	1.20	(1,29)	4.88*

* p. <.05

Table 8

Mean Ratings of Subjects' Reports on Perceived Supports for Organizational Change Readiness

Survey Item	Management Group M	SD	Board Members M	SD	df	F
Structural	6.68	4.80	14.00	3.54	(1,29)	16.96**
Technical	1.36	1.87	3.89	1.36	(1,29)	13.43**
Climatic	4.68	4.79	11.11	4.54	(1,29)	11.82*
People	4.55	4.37	9.89	4.34	(1,29)	9.58*
Systemic	2.82	2.63	8.11	2.32	(1,29)	27.58**

* p. <.01, ** p. <.001

statistical significance in how Board members responded to the following: Structural, Technical, Climatic, People, and Systemic Readiness.

According to Jones and Bearley (1986), an organization's structural readiness is determined by its ability "to keep a clear vision and to reorganize quickly and easily in response to external change and opportunity." Technological readiness refers to "the ability to remain current and innovative in the exploitation of material resources and know how." Climatic readiness means "having an internal ambience that supports people and planned-change efforts," and systemic readiness indicates that an organization has "systems in place that scan and provide information necessary to monitor effects of change" (p.5). Figures 1 and 2 provide a graphic representation of the OCRS aggregate scores for both the management and the Board groups. Depending on one's place within the hierarchy of the organization, very different perceptions were possible. Figure 3 shows the pattern of all subjects' composite scores on the OCOS. Although the pattern looks almost multidirectional, there is a slight inclination toward a Board and management combined, nonfunctional reaction to change (Jones & Bearley, 1986)

Prior access to information about Total Quality Management had no significant relationship to perception about the organization's readiness for change. The

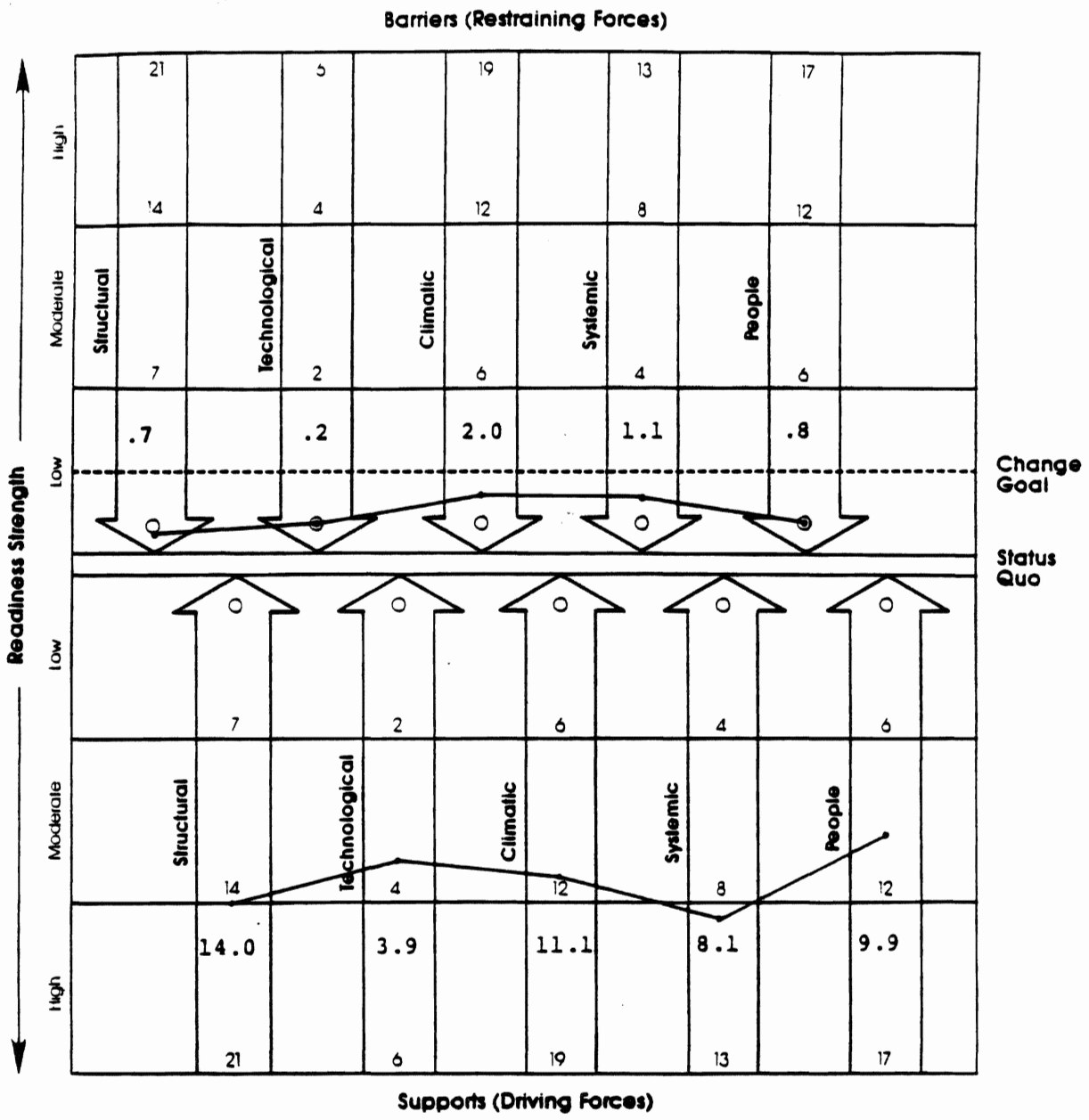

Figure 1. Force Field of the Board Member Group Mean Scores on the Organization Change Readiness Scale.

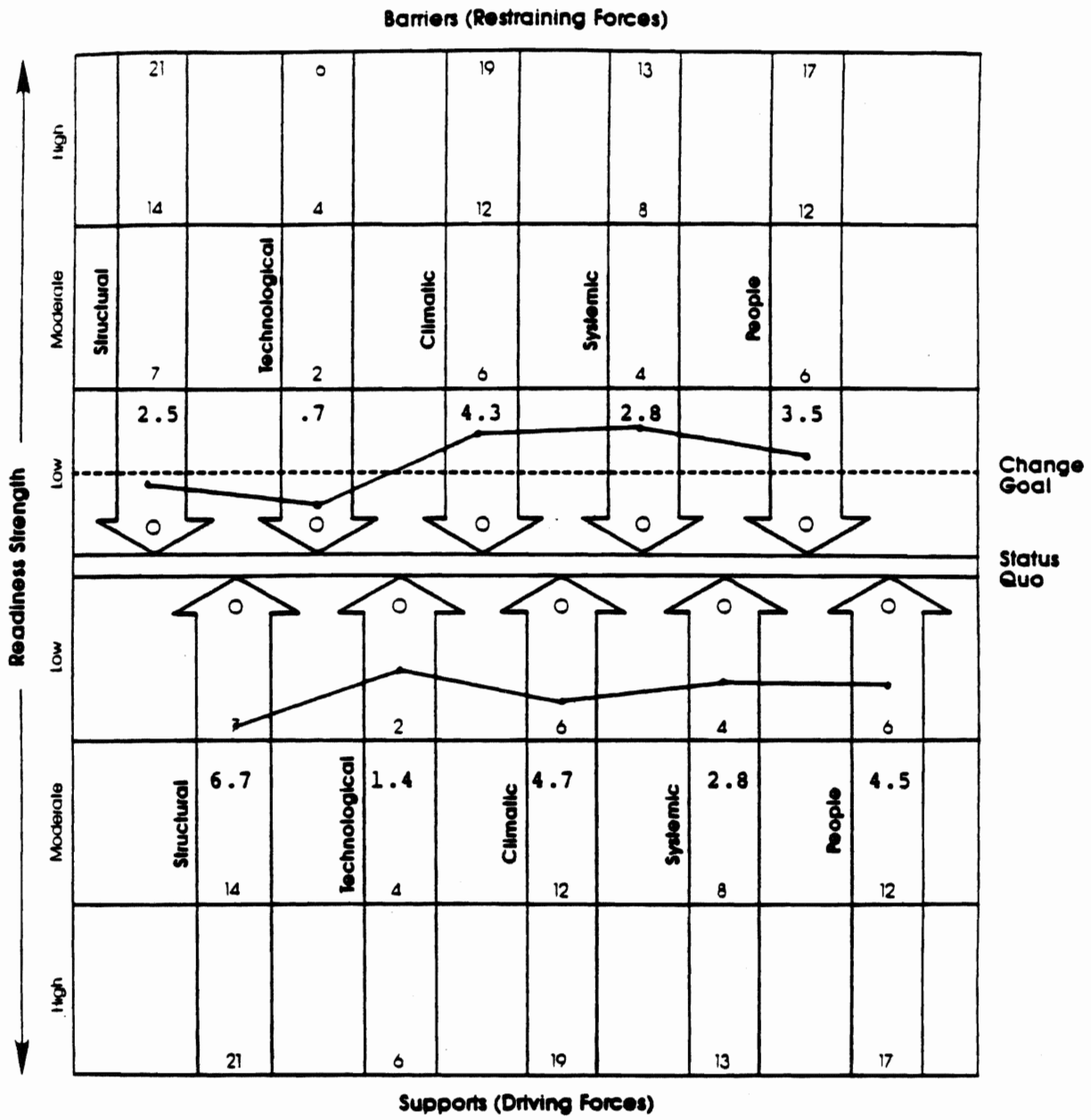

Figure 2. Force Field of the Manager Group Mean Scores on the Organizational Change Readiness Scale.

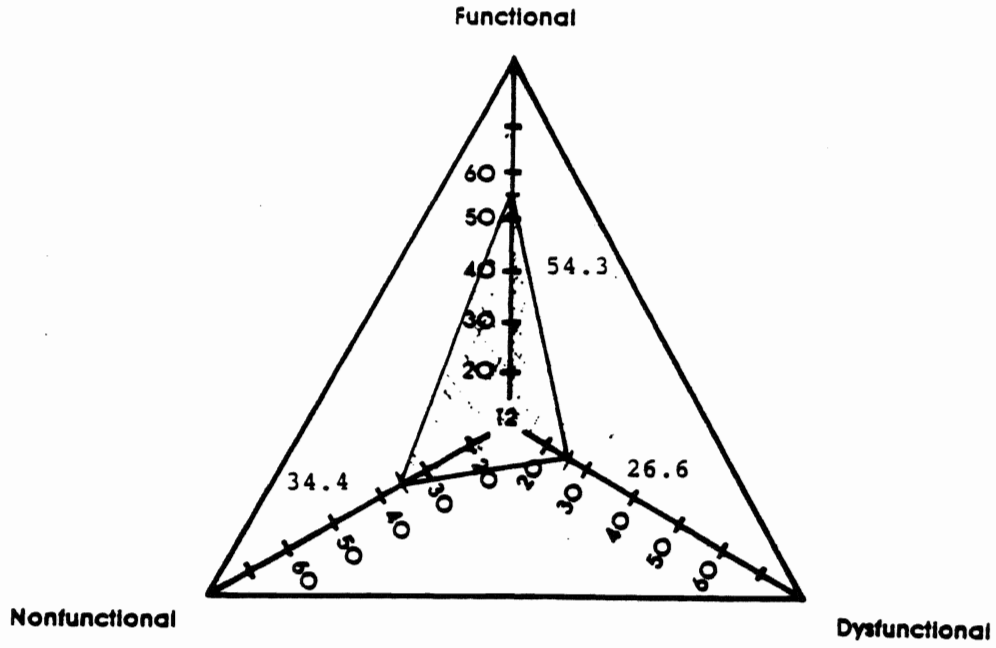

Figure 3. Board Member and Management Group Mean Scores as Plotted from the Organization Change Orientation Scale.

graphic and statistical results of the quantitative analysis component of the study in combination with the hospital's Mission Statement, in which are found explicit purpose, vision, and values, granted a way in which to address organizational supports for and barriers to the adoption of Total Quality Management with Department Managers and with selected representatives of the Board of Governors. In essence, the Mission Statement, periodical, and outcome of the survey process had laid common ground upon which to begin the interview process. Pertinent interview questions for Department Managers were based on the graphic configuration of their survey scores and those of Board members. While the management group had identified few barriers to change, neither had they identified many supports. Their collective perception of the organization was one of status quo, that is, the opposing forces, facilitators and inhibitors to change were equal.

Phase Two: Artifacts Findings

Two sources of artifacts were used to identify explicit organizational values, The Public Hospital's Mission Statement and a marketing publication, The [Public] Hospital: Committed to the Community's Continuing Care Needs. A shorter version of the four-page hospital Mission Statement was rewritten in the winter of 1992 as a

collective effort between the Board of Governors and the Executive Director. To assist the leadership, written suggestions for input into the revision procedure were solicited from general staff. However, no additional opportunities for clarification of vision, values, or purpose were sought. The final product was mounted and displayed throughout the facility. Making the Mission Statement public at the local level of the organization was thus accomplished with neither introduction nor an opportunity for information sharing between organizational levels concerning its full meaning.

Four core values are identified within the document--commitment to customer satisfaction, continuous improvement, partnership, and mutual respect. These stated values comply with those of a quality-focused organization (Deming, 1986; Juran, 1989).

Advancement of the mission, vision, and values was made to staff, patients and the community at large through the publication of a periodical (May 1992) intended for general marketing purposes. Within the context of this publication, the then-Chairman of the Board of Governors was asked, "On a day-to-day basis, what key resources does The [Public] Hospital depend on?" He is quoted as having replied,

> The [Public] Hospital's most valued resource is its people. Our Medical staff, our employees, our auxilians, and our volunteers are, together

> responsible for the special kind of care this facility provides. The [Public] Hospital is much more than bricks and mortar. It's a place of care. It's a place of hope.

To honor a commitment to anonymity, a copy of the May 1992 periodical, The [Public] Hospital: Committed to the Community's Continuing Care Needs, can be obtained through the researcher.

Hospital-wide acceptance of the stated purpose, vision, and values contained within the Mission Statement as well as within other public documents would be indicative of Deming's (1986) ideal of constancy of purpose and with Senge's (1990) belief in the necessity of shared vision and mission as fundamental requirements for organizational effectiveness. Essentially, the documented statement of purpose serves as an explicit promise to patients, staff, and community that the mission, vision, and values contained therein will be upheld by The Public Hospital. The expectation within a quality-focused organization goes even further. In such an organization the values are visibly and behaviorally demonstrated on a day-to-day basis in every action and interaction (Clemmer, 1992; Juran, 1989; Senge, 1990; Whitely, 1991).

Phase Three: Qualitative Findings

Inquiry was undertaken to examine five thematic concepts associated with organizational effectiveness:

shared vision and mission, organizational learning, empowerment, reward and recognition, and leadership and behavioral norms (Deming, 1986; Juran, 1989; Kilmann, 1989; Senge, 1990). These themes were also reflective of the categories addressed by Jones and Bearley (1986) within the Organizational Change Readiness Survey. Questions were loosely structured to enable wide latitude for respondents to express their views. Length of service for the Department Management group ranged from nine months to 35 years. For interviewed Board members, length of volunteerism on the hospital Board extended from six to 20 years.

During the interviews, there was shared agreement by both Department Managers and Board members that "Patient care is our constancy of purpose." Many respondents noted with pride that, "We are The Public. We give excellent care!" However, a common motif woven into Department Managers' responses about constancy of purpose also indicated a gap between that which was stated and that which they saw behaviorally manifested by the senior management team. Such incongruity is in opposition to a single-mindedness toward excellence in patient care. Although The Public's stated core values specific to quality patient care and staff respect were deeply held by Department Managers, they expressed doubt that the same depth of commitment existed at the level of the CEO and

senior management team. Image and finance, as opposed to quality of worklife and excellence in patient care, were often cited by department managers as the drivers for decision-making by the senior management team.

> What really matters is how good we look in the community, how well we get along with the Board and whether the Board thinks we're doing a wonderful job.
>
> Even though they give lip service to oh, yes, we must be wonderful for patient care, unconsciously he (CEO) really doesn't care about the staff or the patients...I see the Mission Statement as lip service.
>
> The system doesn't expect excellence, doesn't know what excellence is nor does it have a desire to find out.
>
> [Our constancy of purpose]...not to go into a deficit position although our Mission Statement says otherwise.

The idea of lip service about commitment to people and to excellence in patient care, distrust and decaying morale became a common refrain throughout the Department Managers' interviews. Many managers expressed their conviction that the motivation for talking commitment to excellence resides in the desire to present well to the Board and to the community. Basically, Department Managers asserted a commonplace conviction that incongruity was evident between the explicit Mission Statement and its implicit interpretation.

> All is cloaked behind a veil of doing the right thing, great facility. These are platitudes; senior management is in denial.

> The difficulty I have is between what's said and what's done. What's presented as who we are and what we're doing and where we're going is one thing, but when it actually comes down to that being done, to me anyway, there seems to be a rift there for saying one thing and doing another.
>
> We keep hearing a bunch of words without meaning. People are disillusioned.
>
> Finances are the only bottom-line issue. Where you would normally think that, O.K., financial concerns are very real, they have to be tempered with honest concern for the people. But, it's not. It [financial concern] becomes the major focus or is the major focus, although again, there's some lip service given to people.
>
> [Our] influence upward depends on the issue. If it's financial in nature, it gets a response. The people issues, the touchy-feely stuff gets a cold shoulder.
>
> There's attempts made at certain times but there's no constancy. Even the staff perceive that staying in the black is the bottom line. They know they're second. Well third actually, first it's the money, then the patients, then the staff.

Arising from shared vision, mission, and values, a clear organizational direction is tantamount to successful change efforts (Deming, 1986; Juran, 1989; Senge, 1990). Everyone in the organization should be aware of the planned strategic initiatives that support organizational goals, both short- and long-term. When interviewed about the Public Hospital's future direction, respondents at both departmental and Board levels shared a sense of confusion. From the Board members' perspective, lack of clear direction was in part accounted for by the indecisiveness of the Ministry of Health. Board member responses included,

> I don't think we have a vision. We're uncertain as to where the Ministry of Health is going so it's hard to establish a vision. Patient care is our direction.
>
> We just spent one hundred and fifty thousand dollars on consultants to help us plan an expansion, to build a day hospital, to be a leader in gerontology. All that is dead in the water. The fact that we don't know where we're going in Long Term Care is causing despondency at the Board level.
>
> Where's the report from the Ministry [of Health] on the redirection of Long Term Care? We've had three of them, one from the last three governments and none of them is definitive.
>
> Every time we made that step as a Board to do something, we were shot dead in the water.
>
> My opinion is that chronic care hospitals will be shunted from the Ministry of Health to the Ministry of Community and Social Services.

Other Board members where less specific in their responses about the establishment of direction.

> I don't care what I accomplish. I just want to be in as good shape as I can be. ...We need to take what we've got and try to run with it. We need to blow our own horn more.

Lack of clear direction at the Board level is echoed throughout the Department Managers' own sense of confusion about the hospital's future.

> There isn't any direction, or maybe it's so diverse that we have no clear focal point to pursue.
>
> The goals and vision are unclear...if we're changing, we're changing at random.
>
> Our role has been fluctuating. One day I'm on this track of early discharge into the community --more out of hospital care. The next day, we're concentrating on more maintenance and prevention. O.K., this means more slow paced rehabilitation.

> I don't want to be unrealistic [about early discharge] if the rest of the team is thinking maintenance.
>
> I went around saying, "Are we expanding the hospital? What are we doing?" Did I get a straight or consistent answer from anyone? No. It was always varied. There is no definite story between each person. Do we know what we're doing?

One department manager did report a belief in a definitive direction but could not elaborate,

> I think it's held by the senior level. I think that's the way it's got to be for now. In time it will go down and reach other areas.

When asked how The Public Hospital could maintain its competitive position to remain viable in the future, one Board member answered, "We're lost at it. I believe that if we gotta go, we're going to go." Department managers held similar convictions about the hospital's organizational capability to remain viable in a changing health care climate.

> I get some information but it doesn't include what the direction is. I think we're in a very precarious position right now. It's a very crucial time for us and Long Term Care...it's make it or break it time.
>
> I see chronic care as more complex patient care. That frightens me because I don't think we're ready to handle a more complex patient population. We lack the professional skills and competencies.
>
> The demand is out there and I think we have to move. If we don't move, I think the hospital will lose it's funding.

The idea of competencies and skills at the front-line, in senior management, as well as within

themselves was often cited as a real concern for Department Managers.

> I honestly think that among the [department] managers the fear is not necessarily with themselves. They are very interested in being progressive. The fear is at the top. There are a few in senior management who I believe do not possess the competencies to lead the organization into the future.
>
> There are pockets, fragments of knowledge in senior management but their biggest tendency is to wait and see. We're reactive rather than proactive.
>
> I don't necessarily think that the organization values learning. I get the feeling that they [senior management] want us to do all this but they don't want to pay for it. They don't want to give us the time, the money, whatever it is for us to move in a particular direction.
>
> They want the image, and they want us to do a good job, but, somehow they think we can learn by osmosis.
>
> There are expectations of their people without investment in them.
>
> The education budget has been slashed. The book budget has been slashed so if you're not able to order books to find out what changes are going on in your field and you're not allowed enough money to attend conventions and things, I'd like to know how we're supposed to be informed.
>
> We are so stretched to the limit. I would like to be out there learning all the time but there isn't the support system behind [us] to learn, to change.
>
> I find for [the front-line] it's very frustrating. ...we would like to have someone with us to help us develop our skills so that we can provide care to a more complex patient...there's a barrier because there isn't the funding.
>
> We're told that the hospital supports education, training, that people are seen as the most important resource. But in action I'd say no, this isn't happening. It's given lip service...it's fine for me to show interest in taking a course but you're only really given approval to take the course if you

> can find funding from some place else. So how much true support for learning is that showing?
>
> I don't think at The [Public] Hospital you are encouraged as far as getting ahead in your career.
>
> From the Board members' perspective, the hospital's past focus was to make money.
>
> Our hospital was run to make money. We were very parsimonious. We didn't buy anything...we're one of the last ones to get a computer.
>
> Being so concerned with money meant that our administrative systems in the actual day to day running were less efficient...we just got our Human Resources person 2 years ago. We have the same number of staff but this person was never thought of before. ...Well, in today's age, you have to have these people and computers.

Bearing in mind that the Department Managers as a group believe that the primary concern for the senior management team is financial solvency as opposed to quality of patient care or of worklife, there was considerable frustration expressed over the allocation of the hospital's resources. If resources were not being invested in knowledge and skills development of those who produce care, the organization strategic advantage, what were the Department Managers' notions about resource allocation?

> Whenever I have asked for new equipment I have to prove I really need it. I have to go through several studies, statistics and so on.
>
> I have to fight for whatever resources I need for the department and yet it seems to me in other areas of the hospital where somebody [an AED] wanted new wallpaper or carpets or a desk because they weren't going to move into that area until things were done,

no problem.

I have no idea. Sometimes it depends on who you know.

The basis for decision-making is cost and patients. Whatever we do, we must have the resources.

Finance is perceived as always getting everything, and they do--brand new desks, oak desks, more staff.

There are the have and the have not departments. Some of the have departments like the lab generate income. Any department that generates income of any kind, gets. Anyone who doesn't, if they just have patient interaction, well that doesn't count.

Finance Department appears to have a lot of staff. If patient care is our primary focus, why do we seem to have a larger ratio of staff in Finance?

There's a sense of frustration that departments can't get the resources necessary to do their jobs. This seems to be more in the non-patient care areas. It's harder for the higher ups to understand how educating or helping employees impacts on patient care.

The dissatisfaction surrounding resource allocation spilled over into decision-making in general. As the interview process continued, it became evident that the traditional structures that supported decision-making at the hospital were an additional source of disgruntlement. The most significant issues for Department Managers rested with their conviction that they were not meaningfully included in the decisional processes. Decision-making seemed disjointed, and once decisions were made, Department Managers believed that there was no expectation of follow-through. In contrast to the stated values of continuous improvement and partnership, very often

respondents spoke about being blocked or in some way thwarted in carrying out plans that they saw as important for their area of responsibility.

> We don't trust the people at the top to make the right decisions because of the finance focus and the short-term thinking.
>
> If decisions are made. That's what's so frustrating at times, that decisions aren't made. It's like why bother because nobody's going to say yes or no. Why beat my head against a wall?
>
> There is a fear of hearing no. Then all of this [change to TQM] will go nowhere. You just get so frustrated that you give up.
>
> [Decisions] are made at the department management level as far as we can go and then we try to push them through committees... to upper management and the CEO. We get stonewalled a majority of the time... Problems don't get solved at all. We just have to muddle through.
>
> When I was reporting to the CEO, there was never enough information supplied to him. Now, I have another report, the AED. It's just another level to try to get through.
>
> You try and improve but, it gets to a certain point where it needs approval and it's blocked off. It just takes so long to get anything done.
>
> Things get lost, they get shoved aside on the agenda, put aside. You keep asking, "Has this been approved? Can we proceed with these changes?" We get nowhere.
>
> Even when we come forward with a minor idea, there's no cost, no jeopardy, but, it's different--we can't get it through. If cost is involved, forget it. It seems we're half a step behind and always incomplete.
>
> We hire consultants who make recommendations then, the Department Manager has to do everything again to prove that the consultant's recommendations are valid. Nothing ever gets implemented. We just keep jumping through the same hoops.

> There are a lot of unimportant questions asked by the CEO. He tends to knit-pick, to stall meetings. He comes unprepared so we have to start all over again at the beginning.
>
> He drags things out...he doesn't understand what the process is...he goes on and on about it ...he changed my wording on something insignificant. His wording meant the same thing but I had to change it anyway. I had to come back with the thing all redone. We lost three more months.

Department Managers' frustration with their inability to effect change through influence at the senior level was echoed in their conviction that the Board of Governors was delinquent in fulfilling its role of leadership at the hospital.

> Our greatest barriers are ignorance and wanting to maintain the status quo and the mind-set of a volunteer Board who thinks they're here to do lunch.

When the Department Managers were shown the graphic configuration of the Board of Governor's composite response to the OCRS, the most commonly held assumptions for the differences in perception between the management group and Board members were,

> I find it hard to see how they [the Board] could come up with this perception except that they have no contact with us. They have contact with upper management and it's important that everything look good.
>
> They're [the Board] being fed information they want to hear.
>
> It has to do with the knowledge they [the Board] possess. They [the Board] don't work here. They're not in the system.
>
> To the Board, everything looks good. They're just seeing the surface.

> They [the Board] may be from the community but they don't represent the people. They're pillars of the community but without understanding of ordinary people.

Board members responses to the same comparison confirmed much of what the Department Managers suspected concerning the Board's emphasis on excellence in patient care, "There is an immense pride in the Board in the way patients are cared for." However, the Department Managers' expectation concerning the administrative role of the Board was in conflict,

> Hospital Boards are volunteer Boards. We don't get involved in management; we're here to govern. I firmly believe that it's administration's responsibility to manage; it's the Board's responsibility to govern.
>
> We don't really get involved in the internal politics of the hospital.

Diminished faith in the comprehensiveness and pertinence of the information presented to the hospital Board may have been confirmed in part by the interviews with the Board members,

> We don't have anyone on the Board who can deal with the Medical side of things. We pretty much let Dr. X tell us about pharmacy committee and things like that. We get more talk about the plant facility...it's accepted that all the patients are happy...it's a given because this is The [Public] Hospital.

A few Department Managers had raised the possibility of staff representation on the Board of Governors. They reasoned that non-voting status would provide an opportunity for improved communication between the front-

line and the Board and could serve as a resource for enhanced information. During the course of Board member interviews, this concept was raised for their consideration with the following comment,

> There is a reluctance from administration and some Board members to put staff representatives on the Board...it comes out of a conflict of interest business ethic...I don't think there's that trust there.

Those interviewed at the Board level tended to share the observations of the Department Management group in that differences in perception were most likely accounted for by the depth of involvement in day-to-day operational affairs.

> I think the difference is dealing everyday, as you guys do, with the problems in the health care sector...and what the Board is still doing in a philosophical way.

An exploration of communication patterns between organizational levels and among Department Managers revealed the existence of stringent barriers to communication and poorly established information channels. Department Managers believed that the senior management team communicates and informs based on need to know. Poor communication, a lack of information, and a belief that those in authority at the senior management level had little appreciation or understanding of subordinate jobs or needs resulted in lost morale and fragmentation.

> I've been assigned an AED who has absolutely no idea of what I do or how the department interacts.

We don't get information we need and I think a lot of stuff is being withheld...I don't really know the reason except they think ignorance is bliss.

There is a lack or understanding about what my job actually entails and what my job is all about.

I suspect somebody knew something that they weren't saying.

We're told what to do. One, two, three, that's all there is.

We have fuzzy jobs with no clear definition or expectations.

We need to work between the levels because if there was no problem in levels, there would be no problem between departments.

They [senior management] could be a lot closer to us than they are. They could share a lot more information than they do...I don't understand why they are afraid to do that, or why they think it's necessary not to.

We're sort of segmented in that we all have different AEDs...we're not allowed to congregate and discuss things as a group. The CEO was approached about that and he absolutely forbade it.

It would be nice to meet with the AEDs and Department Heads and have a real open discussion, but, that's not how it happens.

People don't get informed...communication can also be used as a tool for power, withholding information. I know something you don't know therefore, I'm one up on you.

Groups form between and within levels. Interactions are limited with certain people...everyone is protecting himself. It's very territorial.

There is a lot of secretiveness, a lot of this between you and me stuff going on.

Interpersonal conflict is not limited to departments and levels. Serious discord was also reported among the

members of the multidisciplinary team's clinical peer group. Central to major disagreement is the introduction of untested ideas concerning patient care. In an established clinical decision pattern the introduction of innovative interventions may bring with it a feeling of personal alienation.

> Even though when you explain it and you can visibly and verbally demonstrate how it could be better for the patient, it is still resisted.
>
> I see barriers to change...attitudinal...I think I have never encountered such resistance to change. ...they say, yah, yah, but when so and so was here, they always did it this way.
>
> This is not a place I find excelling in humaness.

Several Department Managers identified coffee breaks as the only true Public Hospital ritual.

> Between 10:00 and 10:30 you can't find anyone around here, even if this place is on fire! There's a certain group and they're gone for half an hour.
>
> I've picked up cliques and what I have learned from that is, maybe I don't take enough coffee breaks to really socialize with people and get to know them and they can't get to know me.
>
> People meet at coffee...I think it would be a problem for those who didn't interact that way.

The coffee break as a social construct also underscored a perception of barriers between the clinical and non-clinical departments.

> My perception is that there are the non-patient care departments and the patient care departments, and there doesn't seem to be a lot of understanding. People go to coffee with different groups...patient services group, they do their own thing...and nobody says how are things going or anything like that.

> We communicate when we have to do something to arrange things, but, the non-patient group can arrange their coffee break, can arrange their own lunchtime. They've got very much control over their day because the patients aren't sitting there waiting for them.

A fundamental source from which to evaluate social relationships and the effectiveness of communication is the monthly Department Head meeting. In reality the Department Head meetings seem to be satisfying the communication needs of only one half of the management equation, the senior management team.

> I don't like the way they're called, 10 minutes in advance...I don't learn a hell of a lot from them.
>
> We have department head meetings and we're talked down to, and he [CEO] gets frustrated with us because we don't ask questions, but when we do, we're jumped on...we're made to feel that the questions are inappropriate. They may be but, it's because we're uninformed.
>
> I've spoken up [at Department Heads' meetings], both on my own and in support of what somebody else was saying, which may be a little controversial...we were just trounced on!
>
> I prefer not to go...you can't talk about anything seriously...
>
> If you're asked for your opinion and you give it, or if you're asked if there's a question, you're told that's the way it is. Next time you're in that situation, you don't ask any questions.
>
> You can't speak your mind especially in front of others at department head meetings. He'll [CEO] try to make you look foolish if he doesn't like what he's hearing.
>
> He [CEO] gives us two messages, tell me and don't tell me...it's tell me but only what I want to hear. Z tried to tell him the truth but he [CEO] lost his

temper.

> All you have to do is be at one of the department head meetings to feel the tension. Like everyone would just like to scream but you can't say anything. Especially when he [CEO] says "Are there any questions?", and you know the minute you open your mouth you're going to get slammed. So, of course everyone just sits there and looks at each other while thinking lots of things we could never dare to say.
>
> Department head meetings are good to the extent that they are one-sided. We're being told what happened at the Board meeting. Other than that seldom does a department head talk about problems if there has been a problem.
>
> Very tense, very tense, a lot of tension and fear if people say something, they'll be challenged in front of their peers. There is a real reluctance to speak out.

The effects of management by control, top down directives, and the suppression of workers' desire for self-expression for the purpose of learning and exploration are communicated very well in the following experience of one Department Manager.

> It's really funny to me...outside this organization I am a functioning adult; I have autonomy. I look after my mortgage payments, I support myself and my family. I don't think I do a bad job. In here, that's removed. I am no longer allowed to have any decision-making authority. I am told what the parameters are [in] which I am to perform my job, and they will not accept any new ideas. They want to maintain status quo. I'm treated like a four-year-old. I just can't believe how they expect people to function.

It is within the context of the department head meetings that behavioral norms, the implicit and unspoken rules of the organization, are most plainly visible. When

asked individually to articulate The Public Hospital's behavioral norms, Department Managers shared without exception the following,

> Keep the Board happy.
> Please the boss, tell him only what he wants to hear.
> Don't upset him, egg-walk.
> Always support him, no matter what his ideas are.
> Don't break the rules but the rules are a moving target.
>
> Don't rock the boat.
> Don't speak up.
> Don't be honest.
> Don't tell the truth.
> Don't ask any questions.
> Don't give your opinion.
> Stay in your place.
> Mind your own business.
> Don't try anything new.
> Don't be innovative.
>
> Don't risk.
> Don't make a mistake
>
> Keep within budget.
>
> You can show initiative if it doesn't cost money.
> If you can't see an end point and it's going to cost money, then don't bother.
>
> Do a good job without complaining.
> Do a good job...perfection.
> A good day's work for a good day's pay.
> Don't expect too many thank yous.

Perhaps the most revealing comment was, "don't reveal the behavioral norms." Frequently expressed was a need for reassurance about confidentiality, and that, within the final text, no one would be able to recognize the owner of the comments. Often, Department Managers apologized for their comments, stating how difficult it was for them to be revealing deeply guarded secrets.

Other respondents showed open anger toward their working conditions, readily offering perceptions about their personal experiences and those they had witnessed. Department Managers, too, expressed the notion that their own style of management was more constructive than that with which they were expected to cope.

> Most department managers are professionals. They know the job others are doing and have respect for the frontline. Most [department] managers have come from the front-line so they know what it's like. That's the reason we try to buffer the conditions between the top and the lower part.
>
> There are two sets of rules, those for working up and those for working down. Department heads try to work with their staff, to value them as people. I think we're more functional.

Others used the analogy of a family to describe their way of coping with the experience of their work environment. The idea of members of an organization interacting in much the same way as a family worked well during the interview process because Department Managers and Board members frequently used the term family to describe the hospital.

> If the mother's role is to nurture, listen, console, we find our mother among our peers.
>
> The children go underground. They don't like the rules set from above, so they make their own to deal with their own staff.
>
> There are dysfunctional families and dysfunctional organizations.
>
> The family is in trouble... There's a certain amount of health...people who are supportive, people to confide in...I would relate it to children within a

> dysfunctional family who band together to support each other...there's a fear of speaking out. You cannot be totally honest.

Repeatedly Department Managers identified the CEO as the authoritarian father figure, the rule maker, and three of the four AEDs as nurturing peace-making mother figures. Most often, the mothering was viewed as passive, peace at any price--disabling rather than enabling. Many Department Managers expressed doubt in the quality of the interaction or the truthfulness with which the AEDs approached the CEO.

> [The CEO] wants to keep rose colored glasses on for the Board. This makes me unsure as to how truthful the AEDs are with him.

When one considers the Department Managers' sense of frustration with the leadership shown by the Board, the lack of confidence in the guidance and direction coming from senior management, and the barriers to effective communication and information channels, one could begin to understand the significance that autonomy over their functional area held for the Department Managers. One Department Manager described the fear of breeching the implicit rule, "tell them only what they want to hear," as follows,

> We package information. Sometimes we don't give it to them...I might loose whatever autonomy I have to run my department...If I keep them [senior management] ill-informed they don't have to deal with the reality that might force change, and I get to play in my own private picnic ground...it's a payback.

Independence in your department...it lets us exist.

Other sources of fear in the organization centered around job security in a tight economic environment, making the wrong decision and, generally, change. In an environment where such rigid, oppressive norms operate, Department Managers believed that taking a risk could jeopardize their positions.

> Anybody who is a risk taker is dangerous because then they will upset the status quo...you may even be penalized for suggesting a new idea.

> You're juggling all these balls and you're going to drop one...that's what I fear I think...it's screwing up someplace where you should have been doing this and this and this.

On a feeling of pride in one's work, those Department Managers having direct contact with patients seemed to experience greater satisfaction from their work than did those non-patient Department Managers. From a patient care area,

> People take pride in working here. They get positive reactions from the patients ...When the patients make positive comments, it makes you feel good.

For the non-patient care areas, Department Managers were less certain about how they were performing. Although some organizational barometers are in place among peer groups, between levels a meaningful system for reward or recognition does not exist.

> I get recognition from other department heads occasionally; but, no, no, nothing from the senior team. What happens in here is if you do a good

> job, nobody says anything; if you screw up, they let you know.
>
> I get the feeling from senior management, just do a good job, don't complain, just do it and shut up... Our work is appreciated, but we're not.
>
> Nobody said to me that I was off track so, as far as I'm concerned, I must be in the right direction... If you have nothing that's reacting to you then you must be in the right mode.
>
> Instead of praise or anything, he [CEO] is into questioning what my professional role is and how much they [my profession] charge and how they're ripping the public off. I find myself defending my profession.
>
> You do the homework, they'll make changes, even though they're insignificant and then their name goes on it. Then I look like I'm still below them , I'm made to stay in my place.
>
> It's almost shocking to senior management that the staff need consideration. For some in senior management, it's not intentional but, for others I believe it is. Lack of commitment to staff keeps a distance, a way of maintaining control.

An important finding is the recurrent theme that not all senior managers are viewed as obstacles to organizational effectiveness. Consistent over all Department Manager's remarks was the tempering of senior management criticism with the phrases, "not all", "just a few", "some." On closer questioning, a shared perception was established--the senior management team, in their managerial values and beliefs, is polarized. Half (three) are seen as controlling, authoritarian, distrustful of others, and ineffective. The other three are perceived as more moderate, progressive, better listeners and, in some

cases, mentors to their subordinates. The researcher, in working with the senior management team as their TQM coach, has made the same observation. However, senior managers within the more collegial pole were also perceived by subordinates as possessing limited influence with the CEO. Those organizational values behaviorally demonstrated by the CEO were those perceived by Department Managers as most prescriptive within the institution.

One final finding, which will require further study, is the belief among the Department Management Group that gender bias exists at the level of the senior management team. Gender bias was raised as an organizational characteristic by several (66.7%) Department Managers; three of five male Department Managers and nine of 13 females. In particular, the three senior managers whose style is more authoritarian are the same three implicated as holding a bias toward women in the workplace.

> The CEO probably doesn't trust anyone, but [he trusts] men moreso than women.
>
> The CEO deals better with males. [He] is adamant that we use the word chairman, even though all around us people are using the word chairperson. To me, it says a lot about a man that gets upset about a word...it does matter to females and how life is changing outside The [Public].
>
> I would say with one AED gender is an issue. He doesn't work well with women, likes to be controlling, play the boss.
>
> Because Y is a male, there seems to be an awful lot that's done...It's an obvious relationship that because he's a man.

> Just look at the senior management team; it's an old boys club.

Indeed, the senior management team is comprised entirely of males. The role of AED, Patient Care has traditionally been occupied by a woman, generally because the position tends to be held by nurses and the majority of nurses are female. However, when the position was filled, approximately 18 months ago, the successful applicant was male. Because the CEO personally interviewed and selected the new AED, he may have contributed to the perception that he holds a gender bias.

This remains an interesting finding for health care in general, as most hospitals and other health care institutions are staffed chiefly by women in care-giving roles, in housekeeping, dietary services, etc. Whether workers or managers within organizations, women's voices need to be heard. The concepts of teamwork, shared vision, values, partnership, respect, organizational learning, lean toward the feminine traits of nurturing and empowerment, those traits most prized by new management theorists (Deming, 1986; Juran, 1989; Senge, 1990), and certainly by the Department Management group at The Public Hospital.

Phase Four: Group Discussion Findings

The following organizational factors were generated

from the Department Managers during the debriefing of the recognized barriers to the adoption of a TQM paradigm at The Public Hospital.

> Top down management style and lack of communication.
>
> Caste system...all the decisional power is at the top.
>
> The bottom-line mindset.
>
> Lack of senior level commitment and dedication to change.
>
> Lack of respect for senior management leadership.
>
> Gutlessness... Fear of risk.
>
> Time constraints.
>
> Change is too slow therefore, trust is lost during the process.
>
> Lack of skills and knowledge upon which to build changes.
>
> Resistance and anticipated sabotage.
>
> Lack of trust.
>
> Burnout.

After group discussion and team building exercises, the Department Management group did disclose their frustrations collectively and publicly. Within the context of this exercise, many questions were openly raised about future direction. Peers shared concerns and fears. Two senior managers, the AED Human Resources and the AED Hospital and Paramedical Services were sought and invited to join the discussion. They arrived immediately, and the Department Management group continued to air

concerns and to ask questions. The behavioral norm around the suppression of speech had been successfully challenged, and barriers to change, that is, opportunities requiring attention for improvement identified.

CHAPTER FIVE: SUMMARY AND INTERPRETATION OF THE FINDINGS

The purpose of the research was to identify the fundamental leadership values and behavioral norms that shape the corporate culture of The Public Hospital for the purpose of determining the organization's readiness to change to a TQM paradigm. The study findings indicated that collectively, the organization's managers perceived the organization as status quo, while Board members tended toward a more positive corporate outlook. If this was so, what factors within the organizational culture were responsible for the discrepancy in perceptions: manager pessimism and Board optimism? What managerial performance deficiencies were accounting for the hospital's state of inertia? If the Mission Statement proposed care in action, were senior managers, through their deeply held values and beliefs, in reality exhibiting care inaction?

Five thematic concepts associated with organizational effectiveness were developed for the purpose of Department Manager interviews: shared vision and mission, organizational learning, empowerment, reward and recognition, and leadership and behavioral norms. Department Management and Board member perceptions and constructs contained within these themes were then integrated into Points #1,5,8,9, and 12 of Deming's (1986) 14 points to establish benchmarks for cultural evaluation

under the new Total Quality Management paradigm as adopted by the Board of Governors of The Public Hospital. Deming's (1986) points are as follows:

> #1. Create constancy of purpose for the improvement of process and service
>
> #5. Find problems. It is management's job to work continually on improving the system.
>
> #8. Drive out fear so that everyone may work effectively for the company.
>
> #9. Break down barriers between departments.
>
> #12. Remove barriers that rob employees of their pride in workmanship.
>
> (Gitlow & Gitlow, 1987, p.20)

Chronic organizational problems were identified within all of Deming's culturally relevant points. However, most chronic problems seemed to be arising from the absence of a shared constancy of purpose, communicated explicitly (in artifacts and structure) and implicitly (in behavioral norms) by the senior management team's values and beliefs.

Fundamental Leadership Values

The fundamental leadership values of The Public Hospital include an unbalanced commitment to financial strength and protection of the hospital's image, management by control, and maintenance of the hierarchial structure. As such, these values are in conflict with

those espoused within the hospital's Mission Statement--customer satisfaction, continuous improvement, partnership, and mutual respect in all interactions.

Deming (1986) Point #1

Create constancy of purpose for the improvement of process and service.

(Shared purpose, vision, and values)

Summary of Research Findings

1. Board members and Department Managers agreed that excellence in patient care is the constancy of purpose for The Public. In contrast, Department Managers overwhelmingly perceive that the constancy of purpose for the senior management team is financially entrenched.

2. Each group reported confusion over the organization's future direction, custodial care or medical care. The confusion has arisen, in part, from lack of direction from the Ministry of Health concerning the redirection of Long Term Care within Ontario, and consequently, due to lack of direction from the organization's leadership to the Department Managers and frontline.

3. Present Board leaders report a move away from their traditional organizational goal, to make money, toward a greater concern for future viability through service

excellence and quality of patient care. Previous Boards placed their emphasis on the appearance of the physical plant and on the expansion of care giving capacity through additions to the building, and to the acquisition of patient beds.

4. Board members reported higher confidence in organizational effectiveness and commitment to change than did Department Managers. However, until the Belicki (1992) study, the Board had not used evaluative criteria to gain a clear understanding of the quality of worklife and subsequently, patient life at The Public. There is a strong tendency to rely on image above measurable data. Extraneous to day-to-day operations, Board members have very little knowledge of or insight into corporate problems.

5. The current Board Executive makes a strong distinction between the roles of management and Governance and thus have taken a laissez faire approach to the hospital's management issues.

6. The present Board leadership reports an expansion of their own committee structure, thus involving a broader base of Board member participation within decisional processes. Regeneration of a community relations committee is thought to be a positive factor; those involved are energized by the prospect. These changes at the Board level, indicative of a Board attempt at renewal,

may be responsible for a stronger sense of commitment to a change in The Public Hospital's management strategy. Because the Board holds the decisional authority to adopt TQM, members would be more likely to show commitment through involvement and expression of their opinions about change. In contrast, Department Managers with no involvement in change decisions, less perceived authority over actual change implementation, and who must cope daily with organizational issues, tend to hide their opposition to change, preferring to place their energies into coping with the effects of change. This notion is supported by the finding that management, collectively, showed less commitment to a quality improvement paradigm than did the Board of Governors. It would be unlikely that managers would welcome change if it is perceived by them to be outside of their realm of decisional control.

7. One important accomplishment for this Board Executive was the revision and up-dating of the hospital mission statement to reflect corporate values in support of their mission, excellence in patient care. The four explicit core values are customer satisfaction, continuous improvement, partnership, and mutual respect in all interactions.

8. Among Department Managers there is a perceived incongruity between what The Public Hospital's Mission Statement professes to value and that which is experienced

as a result of senior managers' behaviors.

Interpretation

At the Board and Department Management levels there is a common mission, excellence in patient care. The purpose, however, is confused by whether the hospital's role should be one of custodial or medically scientific care. Belicki (1992) also found "that there is no consensus about the Mission of The [Public] Hospital, for example whether it is purely a rehabilitation hospital or whether it is an institution that aims to be both hospital and home" (p. 37).

If the product of The Public Hospital as a business is patient care, then providing excellent care must be the rationale at the core of all decision-making. At the level of senior management decision-making, there is both evidence and perception that financial considerations outweigh patient care. The outcome is an organization in conflict on two distinct mission variables: patient care versus money, and custodial care versus medical care.

Without true constancy of purpose, shared vision cannot be articulated at either the Board or Department Management levels. Without shared mission and vision, there exists no strategic path into the future. This has created confusion and loss of meaning throughout the

organization. The Board's response to loss of direction is to blame the Ministry of Health, and to attempt an effort at renewal through a change in strategic focus. However, the senior management team does not seem fully cognizant of the implications of the shift at the Board level. As such, they continue to operate out of a traditional finance paradigm, further confusing organizational direction. Corrective alignment between the revised Mission Statement and its explicit values with corporate structures and processes is confounded. Furthermore, without Board willingness to engage in a more active leadership role, senior management is free to continue to exercise outdated, inappropriate management practices. Should the current state of Board laissez faire continue, there will be no communication structure by which to accurately inform the Board of organizational status or performance. For all good intentions at a renewed corporate initiative, the hospital will remain inert.

Demoralized Department Managers blame the Board, the senior group, the economy and each other for their experience of the loss of meaning and uncertain direction. Security is sought from the external (Rotter, 1961 as cited in Hoyenga & Hoyenga, 1984); their confidence is deeply wounded. When members of an organization fail to share a truly common vision, a deeply unifying purpose,

conflict easily divides them. Within such an environment, excellence in patient care is inachievable.

Deming (1986) Point #5

Find problems. It is management's job to work continually on improving the system.

(Leadership and Behavioral Norms)

Summary of Research Findings

1. The leadership at The Public Hospital is polarized into two conflicting styles and sets of values. One pole is very authoritarian, the other more supportive and mentoring. The authoritarian pole administrates but has poorly developed managerial and leadership skills; the supportive pole has better management skills, yet they too are deficient in leadership. Slightly more than half the senior managers have received formal education in managerial competencies and leadership skills, but not recently. Although the Board has adopted an entirely different management strategy, only one senior manager has sought extramural education on the new paradigm.
2. The leadership role of the Board of Governors is ambiguous.
3. Top down rules are applied arbitrarily and inconsistently. Senior management has often been

perceived by subordinates as transgressors of their own established policies and rules. One particularly salient norm for senior management is, "With position comes privilege."

4. Behavioral norms, leadership-specific and operative at the Department Management level as well as within the senior team are "Don't upset the boss," "Tell him what he wants to hear," and "Don't bring him a problem."

5. Leadership attempts coming from other, subordinate hospital employee sources are discouraged through senior management behaviors that strongly suggest "Stay in your place," "Don't rock the boat," "Do your job," and "Keep quiet."

6. Committee structure seems to be an opportunity to stalemate the attempts of Department Managers to move their decisions and efforts forward.

7. Follow-through on decision-making is perceived as an unrewarded expectation.

8. Three positive actions coming from the senior management group indicate a constructive effort at addressing the organization's chronic problems: the approval and financial support of the Belicki (1992) study, along with a commitment to follow through with corrective actions, CEO approval of this study, and the establishment of the Quality Council to oversee the adoption of the TQM paradigm.

Interpretation

The behavioral norms at The Public Hospital defy problem identification, thus system improvement. The style of the senior management team is polarized, half as administrators, half as managers/leaders. The administrative half is in conflict with the styles of the hospital's Department Managers, yet its authoritarian bureaucratic style of control is the accepted style. The atmosphere created is oppressive. Identification of a problem is viewed as a corporate defect, something to hide rather than work to improve. The Board remains aloof to the wounded spirit of the hospital's employees, distant in their bureaucratic governance, adhering to their rule of non-interference in management, yet leaving an organization yearning for leadership.

Because subordinate leadership is discouraged, Department Managers and others from within the hospital are denied the opportunity to demonstrate talents and abilities below the senior management level. Therefore, no framework exists upon which to build trust between the CEO and his subordinates. It is a cycle of mistrust and suppression. When the CEO fails to trust subordinates' abilities, he fails to encourage the exercise of their skills. Employees, so controlled, soon acquire a sense of helplessness, losing the desire to try (Seligman, 1975 as cited in Hoyenga & Hoyenga, 1984). As was indicated

within the Department Management interviews, the feeling of having given up was pervasive, as were their reports of burnout (Belicki, 1992).

In this researcher's opinion, if the organizational reality of the Belicki (1992) study fails to move the emphasis at the top (Board and senior management) from the importance of things to the value of people, it would be unlikely that values and style congruencies can be achieved. Problem denial and avoidance will remain chronic; Department Manager attempts at self-mastery, futile.

The serious nature of the hospital's chronic problems makes their resolution undelegable. If the CEO continues to fail to act, and if Board leadership continues to flounder, the system will remain status quo. Excellence in patient care will remain an illusion.

Deming (1986) Point #8

Drive out fear so that everyone may work effectively for the company.

(Empowerment and Teamwork)

Summary of Research Findings

1. Behavioral norms expressed by Department Managers show that fear is evident in speaking up, making a

mistake, risking, trying something new, breeching a rule, upsetting the boss, and being over budget.

2. Because of the Board's uncertain direction, the CEO may be fearful of the unknown, failing to please the Board, of going over budget, of being in a deficit position, of making a mistake, and of looking incompetent.

3. The CEO behaviors that support fear in the hospital's Department Managers include refusing to listen, making oneself unavailable, not responding, withholding information, strongly adhering to committee structure, constantly requesting more information, stalling the progress of meetings, demeaning others, distancing through physical and/or emotional withdrawal, making decisions behind closed doors.

4. Behaviors evoking fear from one member of the AED group include ambiguous behaviors, yelling, fist pounding, angry outbursts, withholding information, blaming, discrediting, pouting, using inappropriate facial expressions.

5. Anxiety from within the AED team may include fear of slowing progress by upsetting the boss, of being excluded from the decisional process, and of being fired.

Interpretation

The incongruity among mission, values, and style is

causing a fragmentation of the organization. When there is no perceived connection between what the senior leadership professes and what their behaviors demonstate, workers cannot trust. When problems are unwelcomed, avoided and denied, self-trust is also undermined. The evidence of the constant emotional stress that comes from working within an environment that is duplicitous is found in the results of the Belicki (1992) study. Burnout is alarmingly present within The Public Hospital's workforce (64.4%), in particular within Department Managers (74.9%); of these, 43.8% are suffering at high levels (Belicki, 1992, p. 30).

Fear may be at the heart of the cynicism, mistrust, poor communication, interpersonal conflict and certainty that "they won't change" described by Department Managers. The we and they scenario, the separation and segregation of levels at the hospital may serve to protect the Department Managers by walling them off as an insulated group. Collectively, they showed similar dysfunctional coping behaviors--blame, excuses, packaging information, telling senior management what they want to hear, avoidance of conflict, reinforcement of the oligarchy through failure to speak up or tell the truth, political gamesmanship, and sabotage. The researcher was unable to get truly insightful answers to the question of fear at The Public Hospital. Respondents could identify fear in

connection with economic pressures, job loss, skills disincentives, but could not reach into themselves or into the organizational essence to a deeper awareness. Anger, as the prevailing emotion, was disconnected from its root, fear. Fear as defined by Ryan and Oestrich (1991), "being threatened by possible repercussions as a result of speaking up about work-related concerns" (p. 21) in this researcher's opinion is so fundamental to the psyche (Kilmann, 1989) of The Public Hospital, that further in-depth study of its root causes would be required before the organization could begin to significantly drive it out.

The quality of teamwork between the senior and department levels is compromised by intimidation, and is therefore less than optimal. Empowerment within such an organizational context is severely handicapped. A fuller discussion of teamwork and empowerment can be found within Deming's (1986) Point #9.

Deming (1986) Point #9

Break down barriers between departments.

(Organizational learning)

Summary of the Research Findings

1. Although organizational rhetoric states that The

Public's people are valued as its greatest resource, Department Manager experience negates this concept. They believe that they are not seen by the organization as worthy of the financial investment necessary to update competencies.

2. Lack of resources supportive of learning is profoundly resented by the Department Management group as well as a source of fear due to the loss of their professional competencies and skills within a competitive business environment.

3. There is an apathy on the part of Department Managers about trying anything innovative. Reports of having "given up" are pervasive among this group.

4. Many Department Managers expressed a frustration at having to fight for resources to deliver care or to fulfill their mandate.

5. Reports of protective coalitions, resource infighting, social (coffee) cliques, colleaguial ostracisms, secretiveness, mistrust, resentments, and internal competitiveness abound. Catalysts for these social constructs tend to be the perception among Department Managers of unfair treatment from the senior team, usually around educational opportunities, resource allocation, or rules application, or due to the introduction of some change imposed without their input.

Interpretation

The Public Hospital, in keeping with the bureaucratic model, is managed in parts rather than as a whole. Segmentation is occurring by level, functional area, department, and professional discipline. Because there is no organizational alignment with the structure and purpose of each segment, each operates in isolation from the other. Neither segmented structures nor processes are capable of supporting corporate strategies. The segmentalist (Kanter, 1983) approach to management is utterly opposed to systems thinking. Each segment, isolated from the whole, can perceive only its own limited egocentric needs (Senge, 1990). The organization is fragmented, working out of separateness rather than wholeness. Finances are allocated, not from a unifying strategy so much as from a limited fragmented understanding of the organization's resource needs, and how best to plan and meet those requirements. Getting one's resource needs met has inspired a breed of political gamesmanship that only raises interdepartmental and professional role barriers. If the hospital's purpose is to provide patient care, why is so much attention devoted to finance? What matters gets reviewed. Artificial turf wars are therefore created by administrators whose only communication with their Department Management team focuses on money and things rather than people.

The clinical multidisciplinary team is itself a reflection of the segmentalized whole. Team members, caught within professional boundaries, tend to carve up patient needs according to whose role gets which need. The professional who transgresses his/her role, who believes that an interdisciplinary innovation or unique suggestion would be appreciated, risks inciting the team's angst. This results in team exile. Health care providers can never adequately address the whole-person needs of the patient unless they are willing to address their own fragmented and distorted understanding of teamwork.

Attention to organization-wide concerns requires a direct connection to shared purpose as a daily operational framework. Because no constancy of purpose exists, global issues surrender to cross-purposeful conflict. To have any true opportunity for health, for wholeness, workers, managers, and most importantly patients need cohesive systems working together in harmony, with shared purpose and values. The Public Hospital will need to invest much time and attention into the requirements of team building and of systems thinking in order to achieve organizational capability.

Another concern raised by the issue of alignment is the inability of the senior management team to set down a learning environment in which individual and organizational growth are encouraged. Without the

foundation of a clear mission, vision, and guiding principles that direct organizational behaviors and ambitions toward improvement, learning cannot be an organizational value. If what gets invested in is what matters, then people, staff and patients have not been a past priority at The Public: appearance has. If continuous improvement matters as a value, then learning about how to improve should matter. The organization's investment in continuing staff development is less than one percent of operations. If quality of care and customer satisfaction matter, then quality should be reviewed, innovation rewarded. Neither of these is currently happening.

Instead, the implicit values and the behavioral norms of the Public Hospital run counter to natural curiosity, discouraging experimentation and, thus, innovation. Essentially, this organization's environment is toxic to learning. One must wonder whether the apathy within the Department Management group, the reports of burnout (Belicki, 1992), the interdepartmental conflict, and interprofessional jealousies are not really the physical and emotional manifestations of an organizational reality that is destroying human potential and the desire to learn.

Deming (1986) Point #12

Remove barriers that rob employees of their pride in workmanship.

(Reward and recognition)

Summary of the Research Findings

1. Department Managers directly responsible for patient care and service areas receive patient feedback. Positive patient comments give managers great pleasure and a sense of satisfaction. Department Managers from non-care areas receive recognition for their efforts less often, except from peers. Both groups of Department Managers report little feedback, either positive or negative, from their superiors.

2. In contrast, Department Managers report attention to recognition of the efforts of their subordinates.

Interpretation

Individuals within the Department Management group yearn for recognition of needs and of efforts. This group of individuals strives to fulfill a commitment to quality of patient care and quality of worklife for their subordinates. They are striving toward this goal, however, in the face of discontinuous organizational systems and processes. While The Public's leadership, whether Board or senior management team, espouse the

importance of human values, its actions do not fundamentally differentiate people as human resources and other material resources. Department Managers struggle daily with an intense feeling of demoralization and role frustration. This finding is supported by Belicki (1992) who found that 74.9% of managers at The Public Hospital are suffering from burnout, 43.8% at the severe level.

Without collaborative decision-making, teamwork, investment in growth and learning, Department Managers in The Public's culture are little more than objects. Because health care facilities are staffed mainly with woman, this feeling of objectification may be manifested as gender bias when in fact it is a traditional system of management in conflict with human values.

Performance feedback, whether to the Board Chairman, the CEO, or frontline worker is fundamental to self-improvement. Without attention to individual growth needs, employees can feel under-utilized and undervalued. Negligence in the provision of effective processes that reward and recognize personal and team effort has the potential to reduce people to objects. Within a culture where individuals are treated like pawns, excellence in patient care is not possible because patients too are viewed as objects to be washed, dressed, fed, done to rather than done with. Belicki (1992) found callous attitudes, rudeness, and insensitive treatment of patients

by The Public Hospital's nursing staff.

Because the CEO's values and beliefs were those identified by Department Managers as most prescriptive of behavioral norms within the organization, the place to address quality improvement is at the senior manager and Board of Governor level. However, the Board will have to develop mechanisms for CEO performance appraisal based on quality leadership variables, and the AED group will have to be willing to provide honest, truthful feedback despite their fear of repercussions for speaking up, and the problem-avoidance behaviors of the CEO.

> Often people do not receive the information required for accurate self assessment and may hold inaccurate images of themselves...poor or inadequate performance can promote avoidance to feedback that could assist to improve image. Therefore, the poorer the performance, the less accurate is the self-image. (Bies & Morrison, 1991 as cited in Daniel 1992, p. 537)

Deming (1986) teaches that workers can only work in systems that are designed and maintained by management. Without managers who provide opportunities for employee involvement, and who solicit worker process-knowledge, subordinates are powerless to change the systems in which they work. Department Managers, too, are bound by the systems and resources made available to them by organizational leaders. However, in healthy organizations, leaders and subordinates collaborate within processes and systems designed to encourage and recognize

thinking, learning, and innovation. Managers are expected to accept decisional authority. They capitalize on the talents and skills of their people, understanding that human beings are the embodiment of the organization's knowledge, thus its hope for change and growth. In the health care industry, where care is the product, and quality of care is the organization's source of pride and competitive advantage, it is imperative that excellence in caring be a leadership ideal for the treatment of employees. Health care organizational leaders are called upon, more so than those of any other service industry, to accept their accountability to make espoused ideals behaviorally visible. The stakes are too high to allow failure.

Saunders (1960), a hospice care physician, has written that caring for the terminally ill is simple but not easy. So it is in caring for the chronically ill organization. Without courage to continually self-assess, to face the chronic problems with leadership performance, and without systems to reward and recognize workers' efforts, The Public Hospital will continue to provide a quality of care and service that falls far short of excellence.

Conclusions

The Public Hospital's readiness for change is dependent upon the senior managers' readiness for change, especially that of the CEO. With visible commitment to a TQM paradigm, to one single all-encompassing mission, and an actionable vision for The Public Hospital of the future, the hospital at large will be ready for change. Department Managers are prepared to accept a direction in which they see themselves as active players, working collaboratively to continuously improve the quality of care and service.

The Belicki (1992) study has provided the leadership of The Public Hospital an opportunity to look openly and honestly at the outcome of their management beliefs, values, and practices. In addition, the findings of this researcher's culture-relevant study compliment those of Belicki (1992), while broadening the understanding of the organizational characteristics that are creating an environment in which excellence in patient care is an improbability. The accountabilities for organizational reform lie with the senior team, who must seriously examine their philosophies about human needs and motivators, their values, and most importantly their own behaviors.

Recommendations

If the hospital is to move into a TQM paradigm, it is imperative to mandate and exploit the following leverage points:

i) the hospital has a congruent mission, a constancy of purpose accepted and owned by all employees;

ii) a deeply unifying vision for the continued existence of the hospital must be articulated and shared;

iii) the senior management team must work diligently on behalf of the expression of that vision to put into place structures and processes for effective information sharing, communication, reward and recognition;

iv) the existence of fear must be accepted and means developed to eliminate fear at all levels of the workplace;

v) the senior management team must work toward a systems-integrated approach to management through the endorsement and encouragement of teamwork, and other collaborative efforts to improve processes;

vi) a learning culture must be created and encouraged.

Otherwise, opportunities for improvement throughout the hospital will continue to be limited, especially at the frontline, the final point of hand-off of quality in patient care and service.

Implications for Theory

When Kanter (1984), admonishes the practice of management by segments; Senge (1990), encourages systems thinking; Deming (1986), argues for constancy of purpose, and Kilmann (1989), insists on getting to the essence of the organization, they are stressing the importance of more than simply the financial imperative. This study has upheld previous notions (Deming, 1986; Juran, 1989; Kanter, 1984; Kilmann, 1989; Senge, 1990; Senge, 1992) about the value of shared mission and vision, the positive effect and organizational benefit of worker empowerment, the corporate potential derived from collaborative learning, and the impact of reward for and recognition of workers' efforts. In addition, the findings support those of Kets de Vries and Miller (1984) who underscore the strength of CEO beliefs and characteristics on overall organizational performance.

Patterns of beliefs manifested in behaviors at all management levels exemplified the tenacity of implicit norms as opposed to adherence to explicit policies and rules. Unspoken rules were much better known than those rules found within administrative policy manuals. Written rules tended to be applied inconsistently while unwritten norms were consistently shared and understood.

Despite the organization's chronic structural and process-relevant problems, a sincere commitment to patient

care permeated the attitudes of the Department Managers. It is perhaps the depth of this commitment that made possible the success of care delivered. Essentially, Department Managers refused to accept the finance-focused mission of the organization at the expense of their ability to care for their staff and their patients. Langmeyer, Myer, Snyder, and Verderber (1992) found that women's corporate mobility tends to be hampered by a belief that females lack self-confidence and organizational commitment. Accurate and realistic feedback are fundamental to increased self-confidence. Commitment follows agreement with organizational goals. Department Managers at The Public Hospital are mainly women (73.7%) who refuse to buy into the values in use, and who receive very limited performance feedback or recognition. These factors support the findings of Langmeyer et al. (1992), and may suggest why women at The Public Hospital would find difficulty being moved or accepted into a senior position.

Criticisms of Total Quality Management

Holmes, (1993, personal communication) an educator within the field of administration, has dismissed Total Quality Management as "flaky, the flavor of the month", believing that its tenacity to survive the test of time is limited. This researcher believes that such conclusions

are born out of only a superficial understanding of Deming's (1986) work.

More serious comments come from Wilson (1992) who has raised six basic "insights that have taken the bloom off the rose" (p. 339): the missionary zeal with which advocates expound the merits of a conversion to TQM, the consequent banishment of Quality Assurance, the absence of in-depth inquiry about TQM's general applicability to all facilities including the "need to access a facility's readiness for CQI" and to "get the politics right", a concern about an "unintentional lack of rigor and honesty in the reporting of CQI achievements", and whether CQI is a real solution to the larger problems within healthcare in Canada--the maintenance of the present system and delivery of quality itself (p. 340).

Schaffer and Thomson (as cited in Wilson, 1992), believe concentration on process can lead to inattentiveness to results, "The performance improvement efforts of many companies have as much impact on operational and financial results as a ceremonial rain dance has on the weather" (p. 341). However, the foregoing seem more cautionary than critical.

Rather than criticize, perhaps DeBono (1993) is more correct to suggest that business should be grateful to Deming as the pioneer in TQM/CQI, and then move forward. DeBono believes that a preoccupation with quality may mean

survival at the risk of obsolescence and complacency.

> The main point is that while the Japanese are much concerned with the housekeeping side of things...they are also concerned with the venture side of innovation. Western companies sometimes think it enough just to get the housekeeping right. Everyone knows that Japanese quality owes its origins to American Edward[s] Deming, who was then largely ignored in the United States because the emphasis was on market development. Today the pendulum has swung too far the other way. There is an obsession with quality to the neglect of venture. (p. 38)

Both Wilson's (1992) and DeBono's (1993) insights are supportive of the preparation of an organizational culture bent on continued learning as pre-requisite to the delivery of quality, and the means by which to generate knowledge for future service quality in healthcare.

Implications for Future Research

This descriptive survey of one chronic care and rehabilitation hospital raises many questions for future research:

1. Is the Public Hospital representative of the norm in health care and its ability to move into a quality-focused management paradigm?
2. Are health care and other publicly funded organizations (e.g., educational institutions) less able to adapt and respond in functional ways, to changing economic, political and social realities than their free enterprise counterparts?
3. What role do educators play in building learning

organizations--those that can generate new knowledge as well as adapt to new information? Is it recommended that educators be appointed senior positions within organizational structures?

4. Because collaboration, team learning, and recognition tend to be more feminine traits, do women fare better in quality-focused organizations?
5. Could the corporate-wide application of the theory of continuous quality improvement (Deming, 1986; Juran, 1989) break the glass ceiling (Langmeyer, Myers, Snyder, & Verderber, 1992)?

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Appendix A

Ministry of Health Memo:

Process for submission of Ontario hospital recovery plans

Ontario

Ministry of Health / Ministère de la Santé

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November 22, 1991

MEMORANDUM TO: Chairmen and Executive Directors
District Health Councils

FROM: Mary Catherine Lindberg
Assistant Deputy Minister
Consumer Health and Planning

RE: Process for submission of hospital recovery plans for 1991/92 fiscal year

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Further to the October 29, 1991 letter to your district health council from the Minister of Health, Frances Lankin, I am writing to clarify the process for submission of hospital recovery plans for the 1991/92 fiscal year.

The ministry will identify to you the hospitals in your district which require a recovery plan. The process is time-limited, as outlined in the attached document.

~~DHCs should concentrate on the service impact of recovery plans to ensure that hospitals in the district/region are not all reducing in one service area, that hospitals and other providers are supportive of plans, and that the recovery plans are consistant with longer-term planning.~~

This process will lead to a more intensive planning exercise commencing in January, 1992 to ensure that hospital budgets for 1992-93 and beyond are balanced, while maintaining an appropriate level of service in the community.

GUIDELINES FOR 1991/92 HOSPITAL RECOVERY PLAN PROCESS

BACKGROUND

On October 29, 1991, the Minister of Health, Frances Lankin, wrote to the Ontario hospital chairpersons and the district health council chairpersons about a new collaborative process between the Ministry of Health, district health councils, hospitals and other affected providers, employees and consumers with respect to the service plans of hospitals with projected deficits.

The Ministry of Health's role in this process will continue to be one of ultimate responsibility for ensuring that hospital fiscal resources are managed in accordance with Ministry policy and provincial regulations. More explicitly, the Ministry will ensure that its policy of balanced operating budgets for hospitals is carried out.

For the fiscal year 1991/92, district health councils will play a facilitative role working collaboratively with hospitals and others in determining and moving towards resolving the effects of service realignments and reductions on the district/regional health care system.

The hospitals, as independent corporations, remain responsible for the fiscal management of their operations. It is not the intent of this process that DHCs be involved in the financial management decisions of the hospital but rather that they provide advice on service issues.

The 1991/92 recovery plan process is the preliminary, time-limited step in a more integrative planning process. The process recognises the limited resources and time available in which to develop, review and endorse hospital recovery plans.

The longer term planning process, which commences in January, 1992, will provide opportunities for more integrated planning ensuring that hospital budgets for fiscal year 1992/93 and beyond are balanced while an appropriate level of service is maintained in the community.

PROCESS

1. The Area Team will identify to the DHC the district hospitals' financial positions as of the second quarter of fiscal year 1991/92.

.../2

ROLE OF HOSPITAL

- Where the hospital is anticipating that program/service realignments and reductions will be part of its recovery plan, the hospital is expected to liaise with the DHC in the development of an appropriate recovery plan.

- The hospital is expected to consult with employee representatives in the development of its recovery plan.

- It continues to be the hospital's legislated responsibility to manage its fiscal resources within available means.

- Recovery plans should be done within the context of a longer term approach to management of limited resources recognizing that hospitals will be experiencing substantially lower expenditure rates over the next two to three years.

- Where a deficit is carried forward, the recovery plan must indicate how it will be managed within the hospital's resources so that it does not contribute to a deficit in the 1982/83 fiscal year.

- Where a hospital currently has a declining or negative working capital position, the recovery plan should address this.

ROLE OF DISTRICT HEALTH COUNCIL

- The DHCs will facilitate the bringing together of hospitals and other participants to ensure collaboration and co-ordination among service plans.

- Where service realignments or reductions are being considered in the development of a recovery plan, the DHC will use its planning expertise relative to the district health care system, to examine community health needs and where possible, alternative strategies with hospitals.

- The DHC and the hospitals will keep the community informed of the status of the process.

.../4

APPENDIX A

RECOVERY PLAN GUIDELINES

The hospital's best estimates for growth, equity and life support should be used.

The recovery plan submission to the ministry will include the following where appropriate:

- outline of internal non-programmatic/service strategies and financial savings implications
- outline of service reductions/realignments with financial savings implications
- impact on human resources; plans for alternate human resource strategies (e.g. redeployment, retraining, attrition, job sharing, early retirement, etc.)
- specialty health human resources issues are identified (e.g. recruitment and retention in underserviced areas)
- demonstrated consultation with employee representatives
- impact on provincial protected programs
- impact on other providers
- demonstrated consultation with other service providers (e.g. homecare, health units, nursing homes, etc.)
- community/district/regional/provincial implications
- summary of financial impacts and adjusted projected financial year end position
- implementation strategies (including timeframes)
- evidence of review by the hospital's Fiscal Advisory Committee
- evidence of review and endorsement by the Board

.../6

Appendix B

Deming's (1986) 14 Points

1. Create constancy of purpose toward improvement of product and service, with a plan to improve competitive position and stay in business.

2. Adopt the new philosophy. We are in a new economic age. We can no longer live with commonly accepted delays, mistakes, defective materials and defective workmanship.

3. Cease dependence on mass inspection. Require, instead, statistical evidence that quality is built in to eliminate the need for inspection on a mass basis.

4. End the practice of awarding business on the basis of price tag. Instead, depend on meaningful measures of quality, along with price.

5. Find problems. It is management's job to work continually on improving the system.

6. Institute modern methods of training on the job.

7. Institute modern methods of supervision.

8. Drive out fear so that everyone may work effectively for the company.

9. Break down barriers between departments.

10. Eliminate numerical goals, posters, and slogans that seek new levels of productivity without providing methods.

11. Eliminate work standards that prescribe numerical goals.

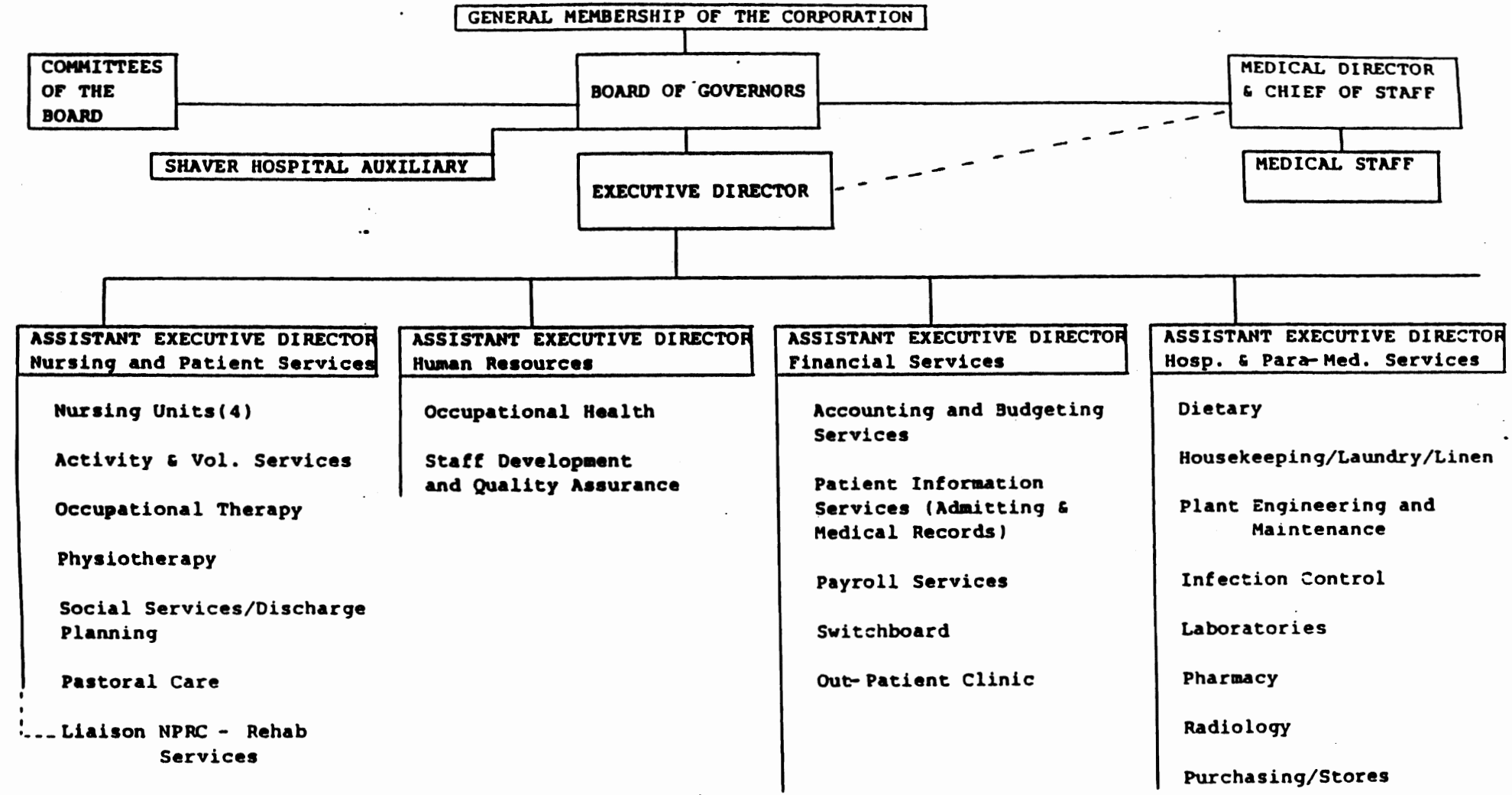
12. Remove barriers that rob employees of their pride in workmanship.

13. Institute a vigorous program of education and training.

14. Create a structure that will push the prior 13 points every day.

(Gitlow & Gitlow, 1987, p. 20)

THE HOSPITAL



_____ Solid line denotes direct accountability

- Broken line denotes communication and professional advisory role only.

November, 1990

Appendix C

The [Public] Hospital's Organizational Chart

Appendix D

Letter to all managers outling the purpose of the study and requesting their participation.

Dear Participant

In December 1991, The [Public] Hospital Board of Governors accepted the following recommendation from the staff Quality Management Committee,

> That the [Public] Hospital Board of Governors and senior managers begin immediately to seek education in TQM/CQI so as to adopt and use the theories and methodologies of TQM/CQI as their corporate management strategy (Minutes of the meeting, Board of Governors, The [Public] Hospital, December 23, 1991).

This decision by the Board created two major opportunities; one for [Public] in that utilization of a TQM paradigm will assist the hospital in improved outcomes and reduced costs, and one for me personally. The decision to change from Q.A. to Q.I. has provided me with a subject for my Masters in Education thesis.

Because the incorporation of Total Quality Management (TQM) into The [Public's] management practices will mean a difference in the way we think about and measure quality, some changes will be forthcoming. These changes will be gradual and come as the result of an investment in the time and resources necessary to be successful with TQM.

CCHFA is also very supportive of TQM, incorporating theory and application into their own business practice. Additionally, they are developing a methodology to survey hospitals who have moved into TQM. In preparation for future surveys it will be important to track where we are going, by ever understanding where we are. The point of my research is to establish a baseline measure before we undertake the change process. In this way, we will be able to measure ourselves against ourselves, over time. It is for this purpose that I am requesting that you agree to take part in the study by fulfilling the attached questionaires.

Because my interest is in a composite score (the average of all managers and Board Members' scores), there is no need to identify yourselves on the instruments. The composite should provide us with a picture of our readiness, as an organization and as a team, to change. Also, it will depict our current knowledge and understanding of TQM so that materials and training can be developed to target our future direction for education based on needs.

<u>If you have received prior education in TQM or have taken part in a Quality Improvement Team at The [Public], it would</u>

be important for me to know this. Therefore, please indicate this by placing a check mark on the outside of your Questionaires.

The study results will be reported to all managers as part of educational programming as The [Public] begins to move toward becoming a TQM organization.

I have read the above, understand the purpose, and agree to take part in this study.

_____ _____

Signature Date

Appendix E

Letter to members of the hospital Board of Governors requesting their participation in the study.

May 11th 1992

Dear Trustee

Attached you will find three questionnaires that have been selected as research instruments in my Masters in Education program through Brock University. The proposed research is titled, Organizational Change: Implications of Culture and Leadership in the Transformation to Total Quality Management. It is my belief that this research will compliment my work at The [Public] and will also serve a utilitarian purpose for the hospital as we move toward Total Quality Management (TQM).

I respectfully request that you, as a Trustee of The [Public] participate in the study for the following reasons:

The research that I am suggesting will contribute to The [Public] Hospital in three very specific ways.

1. By understanding organizational readiness for change, it will assist The [Public] to develop an organizational strategy for change to TQM with an accompanying roadmap (short/long term quality plan). The Board of Governor's awareness is integral to the development and endorsement of such a strategy.

2. It will provide a baseline measure of the organization's level of knowledge and skills in TQM theory and application. This baseline will assist us to measure progress along the path to organizational maturity in TQM.

3. It will guide The [Public] Hospital in the same direction as that taken by The Canadian Council on Health Facilities Accreditation and the Ontario Ministry of Health.

During my most recent work with the CCHFA Total Quality Management Taskforce a great deal of time was spent in discussing organizational culture and the need for cultural changes to be implemented if TQM is to be successful. An organization's culture plays a major role in the readiness to learn, change, and grow. In fact, some of the indicators of readiness and commitment as suggested by the Taskforce are as follows:

- initial and continuing education of Board members
- application of TQM in Board processes

- Board monitoring of TQM implementation
- development of a short/long term strategic quality plan
- evidence of how senior management have organized to implement the vision of quality
- evidence of management's commitment to allocation of resources

In addition, CCHFA will be looking for evidence of organizational maturation in TQM by measuring organizational performance against itself, over time. To accomplish this, The Public would need to establish a baseline measurement of organizational knowledge and behaviors indicative of a TQM organization.

The enclosed instruments are those selected; each requires approximately 15-20 minutes to complete. The expense of the instruments (close to $1,500.00), and the actual research time will be absorbed by me, as researcher. Mr. J. has approved the study and the management team at The [Public] has already taken part.

I ask that you complete ONLY the questions contained within each survey and audit. Please do not disassemble the instruments. Answer all questions candidly. If you find some questions difficult, approach them by placing yourself in the position of manager/leader and answer from the perspective of how you believe you would respond within that circumstance. The scores will be compiled to form a composite of all Trustees responses. Hence, there is no need to identify yourself and any additional comments you may wish to include will be kept confidential.

A final report of the study results can be made available to you, including, if you so choose, a presentation on the findings with a strategy concerning any recommended TQM education/training programs planned as an outcome.

For your convenience, I have enclosed a self-addressed, stamped envelop. I very much appreciate your consideration of my request, and I look forward to receiving your completed surveys and audit by May 25th.

Sincerely,

Beth Meuser, Reg.N., B.A.

Appendix F

Research Instruments

ORIENTATION SCALE (OCOS)

Developed by John E. Jones, Ph.D.
and William L. Bearley, Ed.D.

Organization
Design
and
Development

Organizational Change Orientation Scale (OCOS)

Developed by John E. Jones, Ph.D.
and William L. Bearley, Ed.D.

The purpose of this inventory is to help you to learn some important things about your behavior in organizational change situations. In order to prepare for this self-assessment, think about two or three recent organizational changes in which you were involved. Briefly describe these in the boxes below.

Change A: *How you behaved:*
Change B: *How you behaved:*
Change C: *How you behaved:*

This inventory contains thirty-six items regarding how you relate to organizational change. Referring to the situations that you described above, rate each of the inventory items on the following scale. There are no "right" or "wrong" answers to the items, only what is true for you. Be honest with yourself, and think carefully about each response.

Please record your rating for each item by circling the appropriate letter combination on the Response Form which follows.

Response Scale:

AA	=	Almost Always	**NVO**	=	Not Very Often
VO	=	Very Often	**SE**	=	Seldom
SO	=	Sometimes	**AN**	=	Almost Never

INVENTORY

Directions: Using the Response Form, please circle the letter combination of the response that most closely resembles your personal approach to handling organizational change.

In managing organizational change...

1. I try to find out right away how organizational changes might affect me.
2. I do not get involved significantly in organizational change.
3. I look for scapegoats when organizational changes trouble me.
4. People who know me would describe me as proactive.
5. I tend to "moan and groan" about organizational changes.
6. I hide my opposition to organizational change.
7. My response to organizational change is to ask, "What's in it for me?"
8. I find myself often complaining about changes in this organization.
9. I attempt to undermine organizational changes with which I disagree.
10. I initiate changes that I believe are needed.
11. I do not express my points of view about organizational changes.
12. I sabotage what I believe to be misguided organizational changes.
13. I use systematic methods to make organizational changes work.
14. I take a neutral position on organizational changes.
15. I blame others for my troubles with organizational changes.
16. I try to "stay two steps ahead" in expectation of needed changes.
17. A "wait and see" attitude about organizational changes usually suits me.
18. When I resist changes, I am open about it.
19. My major approach to organizational change is problem solving.
20. I withhold support for organizational changes.
21. I work actively against organizational changes with which I disagree.
22. I am the kind of person who makes change happen.
23. Usually I "go along with" organizational changes.
24. I tend to blame others for problems with organizational changes.
25. I attempt to anticipate the need for changes in the work place.
26. I do not take sides on organizational changes.
27. My normal reaction to organizational changes is passive resistance.
28. I look ahead for potential barriers to goal attainment.
29. I follow rather than lead in organizational change.
30. I use covert methods to thwart unnecessary organizational changes.
31. I take a personal approach to evaluating upcoming organizational changes.
32. I do not actively support organizational changes.
33. I make visible attempts to resist organizational changes.
34. I look for solutions to problems created by organizational change.
35. I participate in gripe sessions about organizational changes.
36. I am not open with my dissent to organizational changes.

RESPONSE FORM

Directions:

For each item, circle the letters of the response that best indicates how often your approach is like the behavior described. Use the following key.

Key:

AA = Almost Always

VO = Very Often

SO = Sometimes

NVO = Not Very Often

SE = Seldom

AN = Almost Never

Press hard using a ballpoint pen. Your responses are being recorded on the scoring form below.

When you have completed your responses, tear along the perforation and follow the directions for scoring.

1			2			3		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
4			5			6		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
7			8			9		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
10			11			12		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
13			14			15		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
16			17			18		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
19			20			21		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
22			23			24		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
25			26			27		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
28			29			30		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
31			32			33		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	
34			35			36		
AA	NVO		AA	NVO		AA	NVO	
VO	SE		VO	SE		VO	SE	
SO	AN		SO	AN		SO	AN	

SCORING FORM

Directions:

Add the points circled in each of the three columns and place the sums in the boxes provided. You will have separate totals for your Functional, Nonfunctional and Dysfunctional behaviors regarding change.

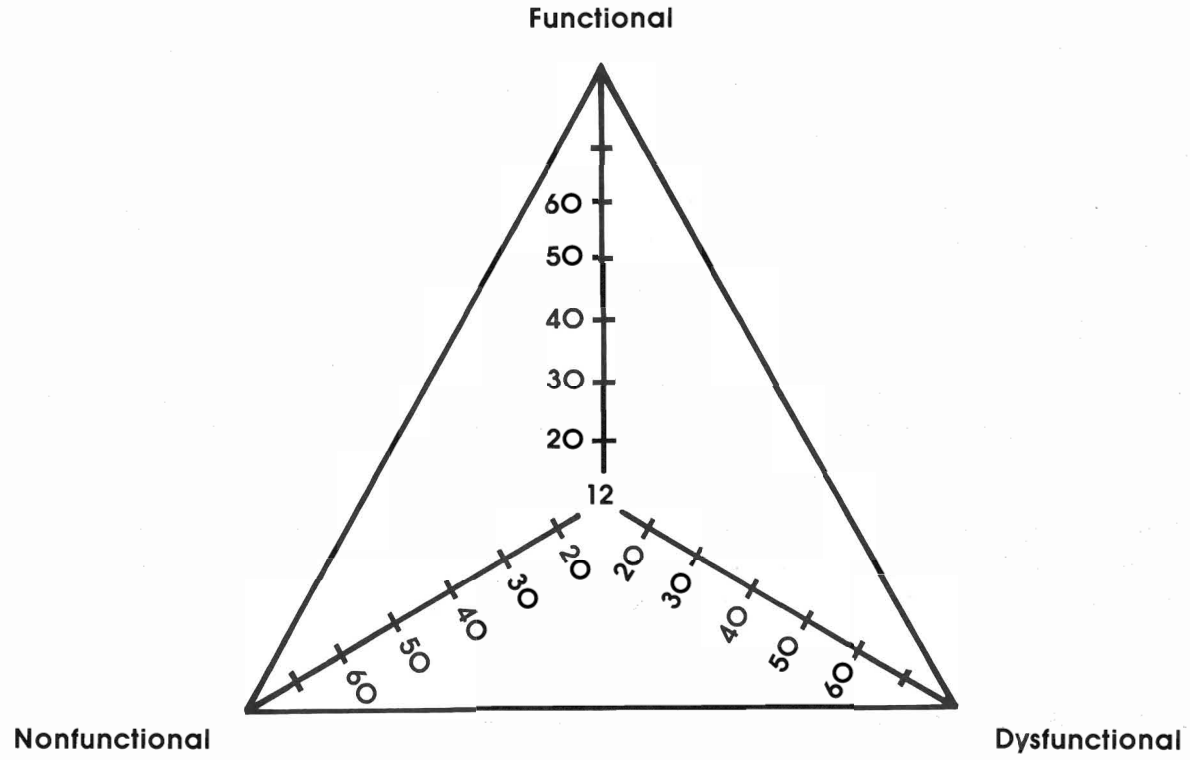
When the scoring is completed turn the page for an interpretation of your scores.

Functional		Non-Functional		Dys-Functional	
1		2		3	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
4		5		6	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
7		8		9	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
10		11		12	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
13		14		15	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
16		17		18	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
19		20		21	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
22		23		24	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
25		26		27	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
28		29		30	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
31		32		33	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
34		35		36	
6	3	6	3	6	3
5	2	5	2	5	2
4	1	4	1	4	1
Totals					

Organizational Change Orientation Scale

Your Orientation to Change—Profile

To create a graphic representation of your orientation to change, place an "X" on each of the three scales in the triangular model below, to correspond to each of the three scores that you calculated on the scoring worksheet. Then, connect these three points with straight lines to form a "triangular" space within the model. Shade in your space. If you scored a "zero" on two of the scales, you will produce a single straight line. If that occurs, darken your line to make it clearly visible.



Interpretation

Responses to organizational change vary widely among people. Some embrace change, others remain neutral, while some resist it, almost in a "knee-jerk" manner. The *Organizational Change Orientation Scale* (OCOS) helps you to see your usual pattern of behaviors related to organizational change. You will be able to see the probable effects of your responses on yourself and the system.

It is useful to consider that the ways in which people behave with regard to change can be classified into roughly three categories, or *three bags full* of approaches. Of course, these categories are somewhat arbitrary, but they help us to make choices about how we can maximize the effectiveness of change efforts. The three categories are: Functional, Nonfunctional and Dysfunctional.

Functional – The first category consists of behaviors that support transformational processes in organizations. The responses are:

1. *Making change happen*

   This is the behavior that is most supportive of organizational transformation. People who behave this way take personal responsibility to initiate improvements.

2. *Anticipating the need for change*

   Personnel who think futuristically also look at the possible effects of environmental change on the system. They are sensitive to the need for innovation inside the organization.

3. *Problem solving*

   This response to organizational change consists of using systematic techniques to make decisions about procedural modifications. The person who is oriented to this behavior looks for ways of making change work.

4. *Self assessment*

   This response is answering the question, "What's in it for me; how will it affect me?" For people to feel committed to supporting alterations in organizational life, they must make a personal connection to them.

These four sets of behaviors constitute *Functional* responses to change. They are proactive, positive, assertive, and productive. People who consistently engage in these responses actively support change. They immerse themselves in organizational improvements and innovation. In other words, they are *moving toward change.*

Nonfunctional – These four sets of behaviors neither support nor resist organizational betterments. The responses are:

5. *Agreement without commitment*

   People who adopt this stance "go along with" changes rather than giving their full support. Verbal endorsement is not matched by supportive behavior.

6. *Fence sitting*

   This behavior involves not taking a stand on changes. People who are either indecisive or unwilling to commit themselves tend to avoid "going public" with their points of view about organizational alterations.

7. *Withholding support*

   This response means that the person is slightly less supportive of change than "fence sitting." Here the person does not work against change but vocalizes a lack of backing for it.

8. *Moaning and groaning*

   Complaining about organizational changes may be cathartic, but it does not aid the process of improvement. People who participate in gripe sessions about system reforms are behaving nonfunctionally.

This category of responses is labeled *Nonfunctional.* These behaviors are inactive, neutral, submissive, and nonproductive. People who display many of these activities are neither supportive of organizational improvements, nor are they significantly resistive. In other words, they are *moving away from change.*

Dysfunctional – The third "bag full" of responses to shifts in organizational processes involves active resistance. The behaviors are:

9. *Blaming and finger pointing*

   Externalizing responsibility for the effects of structural and procedural changes often takes this form. People who engage in this activity are working against organizational renewal.

10. *Passive resistance*

    Here the person is covert in attempting to block change. There also is the denial of responsibility for nonsupport as well as for the effects of change.

11. *Overt resistance*

    People who actively resist change in organizations are sometimes open about it. Here the person publicly protests against modifications. This behavior may include defiance.

12. *Sabotage*

    The most dysfunctional response to change is to undermine it. Resistance becomes covert and destructive. People who disagree with changes sometimes want the changes to fail in order to be right.

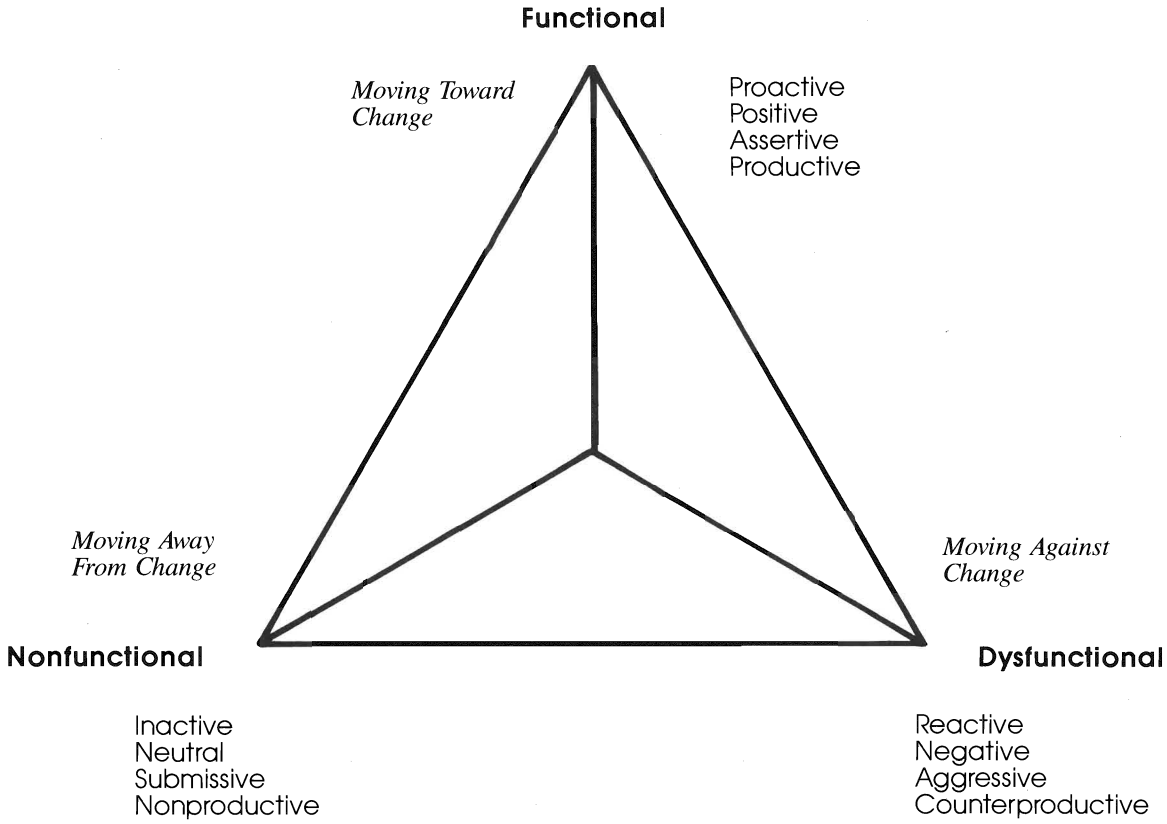
This final category is *Dysfunctional*. The behaviors are reactive, negative, aggressive, and counterproductive. People who resist change often engage in subterranean activities. In other words, they are *moving against change.*

The Organizational Change Orientation Model

The triangular model on the next page shows the three categories of responses to organizational change, with a summary of the characteristics of each. The theory says that organizations are in a continuous state of change and that resistance is inevitable. There always is motion in response to change – moving toward, away from, or against. These three broad sets of behaviors are not mutually exclusive. A person may display any combination of responses to a given organizational-reform effort.

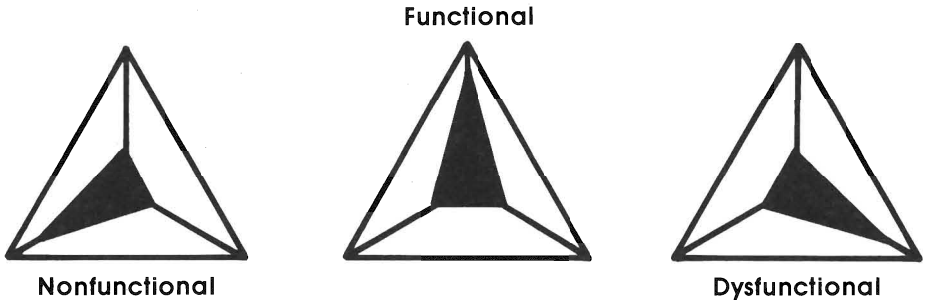
It is important to note that not all resistance to change is negative. When *Functional* activities are applied to improve the change itself to make it work better, such "resistance" is in the service of effectiveness.

The model indicates directions of response to change. What happens inside individuals in the face of innovation is a shift of energy. If the change is threatening, energy is transformed in a negative direction. Some people neutralize their energy when faced with change. When the person sees the potential benefits of shifts in organizational systems, his or her energy moves in a positive direction.



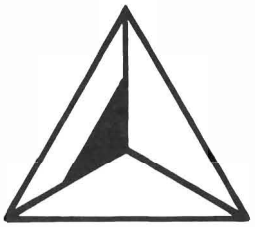
OCOS Profile Patterns

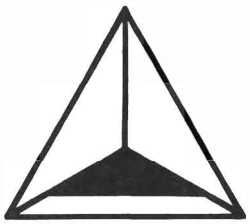
The three profiles below depict individuals who engage primarily in one of the three types of behavioral responses to organizational change. They show a person who embraces innovation in a *Functional* manner, one whose activities are *Nonfunctional,* and one who resists change in *Dysfunctional* ways.



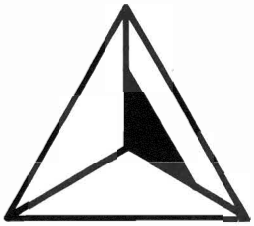
The next three profiles show patterns of behavior that include *two* sets of responses. The first depicts a person who responds to organizational change in either *Functional* or *Nonfunctional* ways (Toward or Away From). The second illustrates a pattern of behavior that is nonsupportive of innovation—either *Nonfunctional* or *Dysfunctional* (Away From or Against). The third indicates that the person possibly is polarized in response to change—*Functional* or *Dysfunctional*—either actively supporting or resisting (Toward or Against).

Toward–Away





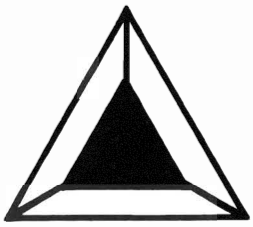
Toward–Against



Away–Against

The final sample profile shows a person who engages in all three "bags full" of responses to about the same degree. This pattern can be exhibited by an indecisive or impulsive person. Of course, this person may carefully discriminate among changes and choose responses accordingly.

Multi-Directional



Your Profile

The profile that you shaded in on page 5 is not your fingerprint. It represents how you would *most probably* behave in organizational change situations. Here are some questions to consider in making sense out of your profile:

1. What is your general pattern?
2. How does it compare with the seven sample profiles above and on the previous page?
3. How does it match your general view of how you behave?
4. What "payoffs" are you getting from this approach to change?
5. How might you be more effective?
6. What proactive behaviors can you start right away?

7. How does your profile match those of your manager, your peers, and your subordinates?

8. How might you work together better to make changes?

9. What do you need to do to improve the way your people respond to change?

10. What changes are needed in your work right now?

Promoting Organizational Readiness

The healthiest organizational situation is for large numbers of people to be engaging consistently in proactive, or *Functional,* behaviors. The most direct way to create that situation is to involve people in decision-making with regard to organizational improvements. System change is ultimately a change in people's behavior. *Nonfunctional* and *Dysfunctional* responses to change can be obviated only by involving employees in ways that lead to commitment.

On Commitment

The ideal situation regarding organizational change would be for everyone to take initiatives for improvements, to share the burden and to capitalize on the opportunities for ameliorating situations that need attention. Most managers, however, fail to reward this behavior and it soon drops out. At best, employee participation in making spontaneous gains in quality and quantity of production could be described as non-functional. When people feel powerless to affect changes, often they resort to dysfunctional responses.

We have said that organizational change goes on all the time. In other words, "the status is never quo." Employees are continuously responding to how they are being treated, particularly to how influential they feel in affecting decisions that affect them. When they feel powerful, they psychologically *move toward* commitment to making the change work for the benefit of the organization. When they feel powerless, they either alienate themselves or engage in resistance.

There is no formula for generating commitment. Clearly, commitment represents an attitude shift toward willingness to support innovation actively. If attitudes can be thought of as rationalizations for behavior, then if we get people to behave differently, their attitudes will "catch-up" later. The *Law of Commitment* states that the first step is behavioral:

> *Meaningful participation* - leads to a
>
> *sense of involvement,* - which evokes a
>
> *feeling of influence,* - that generates
>
> *psychological ownership,* - that results in
>
> *commitment.*

"There is more truth than poetry" in this law. There are no shortcuts to commitment. Rah-rah speeches do not create lasting commitment. People have to work together on organizational change, with a sense of progress, in order to develop commitment. The shift inside the individual begins with seeing participation as personally relevant.

How can you tell whether an organizational change has been made in a way that results in commitment? You are willing to do what it takes to make change work when you have these thoughts and feelings about it:

You will stake your reputation on the change.
You have no lingering doubts about what has been planned.
You are not reconsidering or looking back.
You have no contrary thought about the change.
You have an expectation of winning.
You have left nothing undone.
You are passionately protective of the desired outcomes.
You are intensely loyal to the organization.

Championing Change

Entrepreneurs and "change masters" actively initiate change in order to realize their objectives. They routinely engage in *Functional* behaviors. Their stance regarding innovation is proactive, positive, assertive, and productive. When such leaders are unhappy with proposed or impending changes, their resistance still takes a *Functional* form. They attempt to modify changes to make them work better.

Your Challenge

Since awareness precedes meaningful choice, you already have taken the first step toward making decisions about your personal orientation to change. You are not "locked in" to your profile. You can begin to alter your own responses to organizational changes by first noticing your "automatic" reactions; second, reminding yourself of your desire to modify your stance; and then third, committing yourself to *Functional* behaviors.

Organization Design and Development, Inc.

Organization Design and Development, Inc. publishes experiential learning materials, provides organizational learning experiences, and consults in program design. Founded in 1977, the company is headquartered in King of Prussia, Pennsylvania. The *HRD Quarterly,* a catalog of experiential learning materials for trainers and group facilitators, is published by OD&D Resources, a division of Organization Design and Development, Inc. and is distributed throughout the world.

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Dr. John E. Jones. An independent consultant, John probably is best known as co-founder of University Associates and co-editor of experience-based training and consulting handbooks, and annuals. He consults widely, with such clients as AT&T, GMC, Holiday Inns, Xerox, Burroughs, Kaiser-Permanente, Wallace Computer Services, Turner Construction, Carew Positional Selling Systems, ARC International (Tokyo), Air Canada, and numerous not-for-profit organizations in education, government, health care, and fund raising. John is co-author, with Mike Woodcock, MP, England, of *Manual of Management Development: Strategies, Designs and Instruments for Programme Improvement,* Gower Publishing Co., Brookfield, VT. 1985.

Dr. William L. Bearley. An independent consultant, Bill is an information systems and organization development consultant who combines computer expertise with a solid background in human resources. He has collaborated with John on instrumentation in team building, burnout, and organizational change. He consults with numerous clients, such as Honeywell, Xerox, AT&T and many educational and health care organizations. Bill is a graduate of UA laboratory-education intern program. He has pioneered the fusion of OD with the introduction of management information systems.

READINESS SURVEY (OCRS)

By John E. Jones, Ph.D. and
William L. Bearley, Ed.D.

Organization
Design
and
Development

Organizational Change-Readiness Survey (OCRS)

Developed by John E. Jones, Ph.D.
and William L. Bearley, Ed.D.

The purpose of this questionnaire is to help you analyze the ability of your organization to manage change effectively. It is important that you think of a definite organization in which you are involved directly, so that your perceptions will be valuable in the analysis. Write the name of the organization (division/department/unit) below:

_____

This questionnaire is easily "faked." Each item has been found to relate positively to effective innovation and change in organizations, so you could easily make the organization look good by rating each characteristic high. The analysis would, in that case, most probably be useless. It is vital that you mark each item as you *genuinely* see it rather than how you think it should be. That way, both positive strengths and barriers to effectiveness can be studied.

For each item, indicate the degree to which you believe your organization engages in the practice described. Record your response to each question by circling the appropriate letter combination on the Response Form which follows. Use the key below.

Key:
NA = Not At All
VLD = To a Very Little Degree
LD = To a Little Degree
SD = To Some Degree
GD = To a Great Degree
VGD = To a Very Great Degree

Please turn the page and begin.

QUESTIONNAIRE

Directions: Please use the Response Form on the opposite page. For each item, circle the letter(s) of the response that best indicates the degree to which you believe your organization engages in the practice described.

To what degree does this organization...

1. show the ability to institutionalize and regularize changes?
2. seem forward looking?
3. invest in the development of new technology?
4. show commitment to excellence?
5. have the ability to inspire people toward the unknown?
6. have effective internal communications?
7. stress that every employee is in the marketing business?
8. have influential people who are dissatisfied with the status quo?
9. take decisive action?
10. stick to the business it is best at?
11. stay on the lookout for new technology?
12. have a policy of employee participation?
13. have a climate that supports experimentation?
14. evidence commitment to quality?
15. view its people as resources?
16. have internal change facilitators?
17. show a tolerance for role ambiguity?
18. indicate clearly what business it is in?
19. engage in visionary futuring?
20. reinforce creative behaviors?
21. root its internal politics in improvement rather than in empire building?
22. reward organizational improvements?
23. show flexibility at the top?
24. reward people who are mavericks or nonconformists?
25. have a sales-and-service orientation?
26. tolerate temporariness well?
27. take ideas from its customers?
28. avoid restricting itself by precedent and tradition?
29. support "off-line" innovation (skunk works, intrapreneurship)?
30. have measurement systems to assess the effects of organizational changes?
31. practice participative management?
32. have the ability to manage consensus?
33. have a clear vision of the future?
34. show structural simplicity?
35. show technological readiness for the future?
36. have an expectation of an abundant future?
37. reward mistakes?
38. have the ability to handle disruptions in its internal processes?
39. tie its innovations to groups rather than individuals?
40. experience externally-induced change?
41. have a widely understood mission?
42. have an explicit formula for success?
43. avoid placing undue stress on its people?
44. have intense interactions among its management?
45. have a reward system that is responsive to change?
46. support people who champion change?
47. have a clear sense of direction (where it is going)?
48. seem to be in control of its own destiny?
49. have a proactive climate?
50. monitor its external environment for cues that indicate needed internal changes?
51. have people who can personally handle working in a climate of change?
52. show the ability to cope with paradox?
53. have units of manageable size?
54. have its own unique rituals?
55. have tightly linked systems?
56. tolerate individual differences among its people?
57. show structural flexibility, including having temporary structures?
58. avoid the build-up of crisis situations?
59. have appropriate system redundancy?
60. have employees who are aware of their individual contributions?
61. have a clear set of values (what it stands for)?
62. have a prevailing theory of management that supports change?
63. have bureaucratic forms that are essentially benign?
64. have employees who personally identify with the organization?
65. seem market driven?
66. support democratic values?
67. have effective information systems?
68. have top management that is determined to institute change?
69. experience pressure for change?
70. show a team spirit?
71. provide effective training and education for its people?
72. have the ability to manage conflict?
73. actively choose among alternative futures?
74. have its own mythology?
75. utilize a vision-oriented goal-setting process?
76. have a partnership atmosphere between management and labor?

RESPONSE FORM

Directions: Circle the combination of letters representing your evaluation of the degree to which this organization engages in the practice described in each item.

Press hard. Use a ball point pen.

Your responses are being recorded on the Scoring Form below.

When you have completed your responses, tear along the perforation and follow the directions for scoring.

1 NA SD VLD GD LD VGD	2 NA SD VLD GD LD VGD	3 NA SD VLD GD LD VGD	4 NA SD VLD GD LD VGD	5 NA SD VLD GD LD VGD	6 NA SD VLD GD LD VGD	7 NA SD VLD GD LD VGD	8 NA SD VLD GD LD VGD
9 NA SD VLD GD LD VGD	10 NA SD VLD GD LD VGD	11 NA SD VLD GD LD VGD	12 NA SD VLD GD LD VGD	13 NA SD VLD GD LD VGD	14 NA SD VLD GD LD VGD	15 NA SD VLD GD LD VGD	16 NA SD VLD GD LD VGD
17 NA SD VLD GD LD VGD	18 NA SD VLD GD LD VGD	19 NA SD VLD GD LD VGD	20 NA SD VLD GD LD VGD	21 NA SD VLD GD LD VGD	22 NA SD VLD GD LD VGD	23 NA SD VLD GD LD VGD	24 NA SD VLD GD LD VGD
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61 NA SD VLD GD LD VGD			62 NA SD VLD GD LD VGD		63 NA SD VLD GD LD VGD	64 NA SD VLD GD LD VGD	
65 NA SD VLD GD LD VGD			66 NA SD VLD GD LD VGD		67 NA SD VLD GD LD VGD	68 NA SD VLD GD LD VGD	
69 NA SD VLD GD LD VGD			70 NA SD VLD GD LD VGD		71 NA SD VLD GD LD VGD	72 NA SD VLD GD LD VGD	
73 NA SD VLD GD LD VGD			74 NA SD VLD GD LD VGD		75 NA SD VLD GD LD VGD	76 NA SD VLD GD LD VGD	

Key: **NA** = Not At All **SD** = To Some Degree
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SCORING FORM

(OCRS)

Directions: For each of the five sections, add the number of X's, then the number of O's circled and place the totals in the boxes below each section.

Note: In some cases you will have to add two columns to obtain the totals.

Now, turn the page for an interpretation of your scores.

Structural				Techno-logical		Climatic				Systemic		People			
1		2		3		4		5		6		7		8	
X	—	X	—	X	—	X	—	X	—	X	—	X	—	X	—
X	O	X	O	X	O	X	O	X	O	X	O	X	O	X	O
—	O	—	O	—	O	—	O	—	O	—	O	—	O	—	O
9		10		11		12		13		14		15		16	
X	—	X	—	X	—	X	—	X	—	X	—	X	—	X	—
X	O	X	O	X	O	X	O	X	O	X	O	X	O	X	O
—	O	—	O	—	O	—	O	—	O	—	O	—	O	—	O
17		18		19		20		21		22		23		24	
X	—	X	—	X	—	X	—	X	—	X	—	X	—	X	—
X	O	X	O	X	O	X	O	X	O	X	O	X	O	X	O
—	O	—	O	—	O	—	O	—	O	—	O	—	O	—	O
25		26		27		28		29		30		31		32	
X	—	X	—	X	—	X	—	X	—	X	—	X	—	X	—
X	O	X	O	X	O	X	O	X	O	X	O	X	O	X	O
—	O	—	O	—	O	—	O	—	O	—	O	—	O	—	O
33		34		35		36		37		38		39			
X	—	X	—	X	—	X	—	X	—	X	—	X	—		
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40		41		42		43		44		45		46			
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47		48				49				50		51			
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57						58				59		60			
X	—					X	—			X	—	X	—		
X	O					X	O			X	O	X	O		
—	O					—	O			—	O	—	O		
61						62				63		64			
X	—					X	—			X	—	X	—		
X	O					X	O			X	O	X	O		
—	O					—	O			—	O	—	O		
65						66				67		68			
—	O					—	O			—	O	—	O		
X	O					X	O			X	O	X	O		
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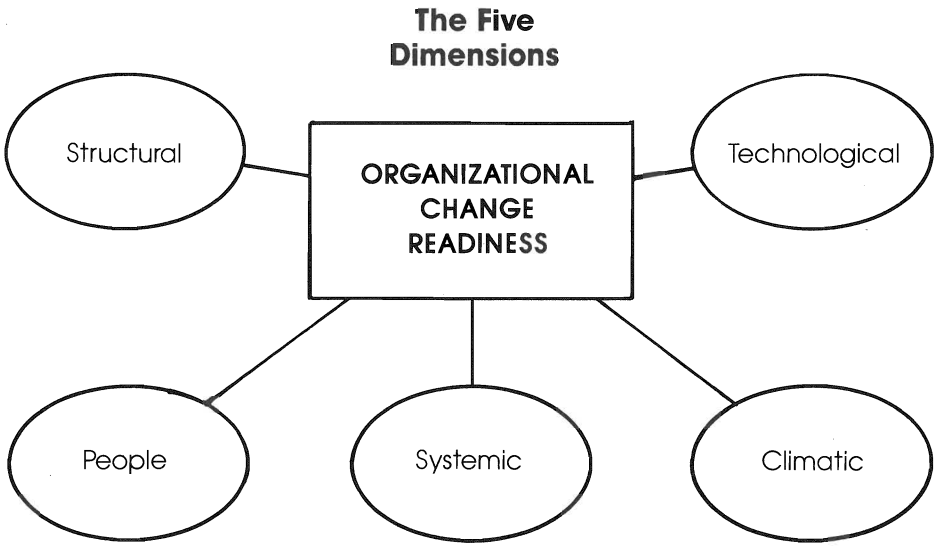
69						70				71		72			
X	—					X	—			X	—	X	—		
X	O					X	O			X	O	X	O		
—	O					—	O			—	O	—	O		
73						74				75		76			
X	—					X	—			X	—	X	—		
X	O					X	O			X	O	X	O		
—	O					—	O			—	O	—	O		
Total X's / O's Total		X / O		X / O			X / O			X / O			X / O		

Interpretive Guide

The *Organizational Change-Readiness Survey* includes five categories of items, each of which is considered to be an important aspect of organizational change-readiness. The five item sets are:

Structural Readiness	The ability to keep a clear vision and to reorganize quickly and easily in response to external change and opportunity.
Technological Readiness	The ability to remain current and innovative in the exploitation of material resources and know-how.
Climatic Readiness	Having an internal ambience that supports people and planned-change efforts.
Systemic Readiness	Having systems in place that scan and provide information necessary to monitor effects of change.
People Readiness	Having managers and workers who can work productively together within an environment that is ambiguous and in flux.

The five dimensions of change-readiness are depicted below. The model shows them as independently affecting readiness. It is likely, however, that these dimensions are correlated with each other within your organization. That is, they may tend to be mixed, or interdependent. Your organization may have several barriers that are likely to multiply each other's effects.



The concept of change-readiness is similar to that of reading readiness. Until a child becomes "ready" to learn to read, hardly any method of teaching will be successful; but when he/she is ready, almost any technique will work. Accordingly, you may acknowledge a need to lose weight or quit smoking; but until you are "ready," you are not likely to succeed. In an analogous way, organizations differ with respect to their ability to manage change productively—their change-readiness. The OCRS maps your assessment of your organization's present ability to deal satisfactorily with change and innovation.

The five dimensions of the Survey help you think about what to emphasize in improving the change-readiness of the organization that you described. You isolated a number of both supports and barriers. The supports are represented by the number of "O's" for each change category. The barriers are represented by the number of "X's" for each category.

Your Organization's Change-Readiness

To obtain a clearer picture of your organization's change-readiness, a Force-Field type chart has been provided on the next page.[1] First plot each of your scores for Structural, Technological, Climatic, Systemic and People readiness. The "X's" should be recorded in the upper portion of the chart in the *Barriers* section. The "O's" should be placed in the lower *Supports* section. Connect the recorded marks in the *Barriers* section to form a plot line; then connect the marks to form a plot line in the *Supports* section. These lines represent *your* perception of your organization's change-readiness at the present time. If your entire work group has completed the Survey, plot the *averages* of the group members Barrier and Support scores. Use a dotted line to distinguish the *group's* perceptions from your own. If your total organization has completed this Survey, you may be able to plot a third set of Barrier/Support scores on the chart.

Using the Force-Field Problem Solving Model to Improve Your Organizational Change-Readiness

The *Force-Field Analytic Problem Solving Model* was developed by Kurt Lewin in the 1940's. His approach provides a convenient and effective method for surfacing the forces that impact a problem and then building a strategy to strengthen the forces for change (Supports) and weaken the forces inhibiting change (Barriers).

The Force-Field approach can be used to deal with the data from the OCRS. In general, you (or your group or organization) can...

1. Build on the *Supports* that you uncovered, strengthening their ability to drive change in the system;

2. Overcome the *Barriers*, seeking to minimize their negative effects on introducing change in the organization;

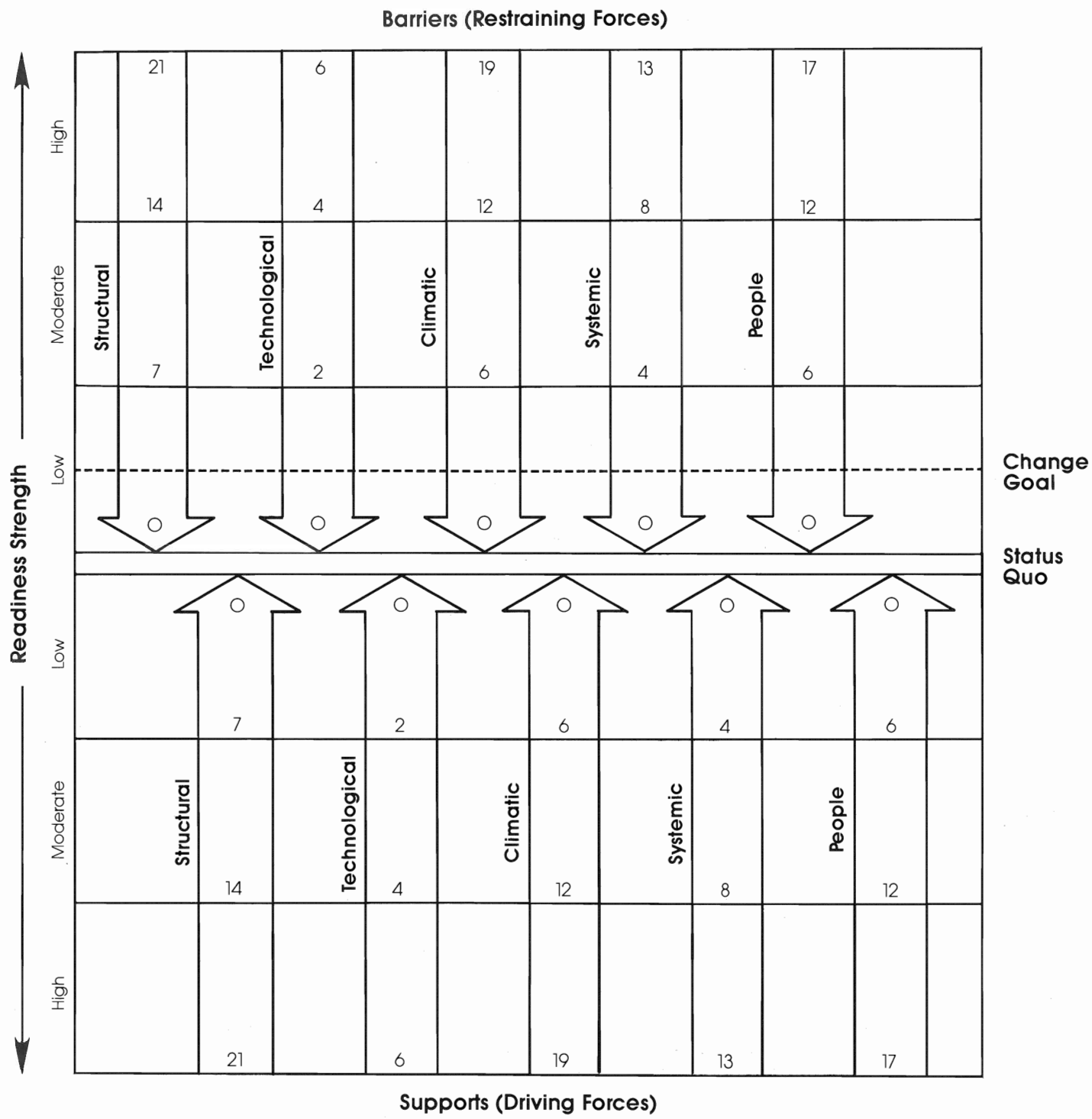
3. Attempt to do both—increase the pressure for change through strengthening Supports and at the same time trying to overcome the Barriers;

4. Do nothing.

Kurt Lewin strongly suggested that the best strategy is to work on overcoming barriers to change-readiness. He has said that any organizational situation that appears to be static can be thought of as a temporary equilibrium of opposing forces. Overcoming organizational deficiencies and resistances permits the natural thrust of supporting forces to push toward productive change.

1. Kurt Lewin is the originator of the Force-Field Analytic Problem Solving Model. The complete exercise is available from Organization Design and Development and could be used in conjunction with the data you have obtained.

Force-Field



Major Change Strategies

The following chart outlines thirteen broad approaches* to initiating change in organizations. Each strategy is described according to its most common activities and its assets and potential liabilities. Study this chart for ideas to improve the Barriers that you identified in your Force-Field diagram.

Strategy	Common Activities	Assets	Potential Liabilities
Clinical	Counseling Psychotherapy Employee Assistance Programs Support Groups Personal-Growth Groups	Sensitive Private Individually Paced Timely Intensive	Must Be Voluntary Low Task Focus Low "Wattage" Potentially Harmful
Confrontation	Confrontation Meetings "Shootouts" Third-Party Interventions Negotiations	Realistic Uses Power Effectively Enrolls Significant People Followthrough	Blowups Stalemates Alienation Avoidance "Getting Even"
Consultative	Outside Consultative Assistance Co-Consultation	Fresh Ideas and Solutions Objectivity Thoroughness Special Expertise	"Canned" Solutions Expense Delay Superficiality Lack of Ownership
Economic	Changing the Reward System Increasing Resources	Quick Conformity Lasting Change Pervasive Effects	Issues of Fairness Precedent Risk of Investment
Educational	Training Seminars Symposia University Programs "Dog and Pony Shows"	New Knowledge and Skills Rewards Preparation for Change	Meeting the Wrong Needs "Canned," "Off the Shelf" "Charm Schools" Little Transfer
Engineering	Changes in Physical Surroundings (Walls, Office Locations, Lighting, Decorations, etc.)	Hawthorne Effect New Alliances Visible Progress Changed Interactions	May Seem Arbitrary or Discriminatory Unintended Effects Poor Communications

*Several of these strategies are adapted from Kurt E. Olmusk, "Seven Pure Strategies of Change." In *The 1972 Annual Handbook for Group Facilitators*, J.W. Pfeiffer and J.E. Jones, Eds., University Associates, San Diego, CA, 1972.

Strategy	Common Activities	Assets	Potential Liabilities
Kampai	Drinks After Work "Power Lunches" Confrontations, with Alcohol	Promotion of Confrontation Low-Conflict Negotiation	Poor Problem Solving Blowups Lack of Followthrough Escapes from Responsibility
Military	Threats Forced Compliance Limit Setting Tight Controls	Quick Clear Use of Power Aggressive Reinforces Hierarchy	Resistance Alienation Hostility Nonconformity Insensitivity
Participatory	Task Forces Focus Groups Sensing Meetings Group Decision-Making	Commitment Varied Inputs Shared Understanding More Expertise	Slow Processes "Ins and Outs" Mentality "Groupthink" Inappropriate Uses
Political	"Horsetrading" Win-Lose Analysis Image-Damage Analysis Deck Stacking	Sensitive to Power Distributions Quick Followthrough Builds Coalitions	Organization by the Disenfranchised Retribution Blowups Resistance
Procedural	Changes in Work Flow and Processes Procedural Fixes Rules Changes Changes in Reporting Methods	Visible Focus on Efficiency Pervasive Effects Quick Fixable	May Treat Symptoms Resistance May Create Two Sets of Rules
Structural	Reorganization Open Communications Changes in Rewards and Accountabilities	Focus on the Manageable Visible Clarity Task Centered	Requires Consensus on Values and Goals May Change Valued Features of the System
Technological	New Hardware/Software Robotics	Improved Efficiency Market Edge Increased Safety	Threats to Job Security Resistance Need to Upgrade People

Planning Worksheet

1. Look at your OCRS profile and find the one or two categories in which your Barriers are higher than your Supports.

   Barrier Category _____

   Barrier Category _____

2. Using the Scoring Form, find those items for the categories identified above where the X's are circled, and circle those item numbers on the questionnaire.

3. Read the items you circled that contributed to the higher Barrier scores. Look for key ideas or characteristics that best describe the barrier.

4. From the table of Major Change Strategies select one or more strategies that you believe would best help to decrease the barrier. Write a detailed plan below for improving these organizational characteristics.

   Strategy _____

   What specifically will be done:

   Who (especially you) will take action:

   When will the action be expected to produce results:

   Where will the action be taken:

   Why is the action being undertaken:

   How much do you hope to achieve by the improvement:

Organization Design and Development, Inc.

Organization Design and Development, Inc. publishes experiential learning materials, provides organizational learning experiences, and consults in program design. Founded in 1977, the company is headquartered in King of Prussia, Pennsylvania. The *HRD Quarterly,* a catalog of experiential learning materials for trainers and group facilitators, is published by OD&D Resources, a division of Organization Design and Development, Inc. and is distributed throughout the world.

Author Biographies

Dr. John E. Jones. An independent consultant, John probably is best known as co-founder of University Associates and co-editor of experience-based training and consulting handbooks, and annuals. He consults widely, with such clients as AT&T, GMC, Holiday Inns, Xerox, Burroughs, Kaiser-Permanente, Wallace Computer Services, Turner Construction, Carew Positional Selling Systems, ARC International (Tokyo), Air Canada, and numerous not-for-profit organizations in education, government, health care, and fund raising. John is co-author, with Mike Woodcock, MP, England, of *Manual of Management development: Strategies, Designs and Instruments for Programme Improvement, Gower Publishing Co., Brookfield, VT. 1985.*

Dr. William L. Bearley. An independent consultant, Bill is an information systems and organization development consultant who combines computer expertise with a solid background in human resources. He has collaborated with John on instrumentation in team building, burnout, and organizational change. He consults with numerous clients, such as Honeywell, Xerox, AT&T and many educational and health care organizations. Bill in a graduate of UA laboratory-education intern program. He has pioneered the fusion of OD with the introduction of management information systems.

Quality Improvement Audit For Leaders

BEST®

INSTRUMENTS

Quality Improvement

For several years, leaders in the United States have been concerned about product and service quality. This concern has been generated by the growth of the Japanese success in world markets. Using Dr. W. Edward Deming's model of management, the Japanese have successfully competed head-to-head with the West.

Now American leaders are beginning to use the Deming and other similar models to improve quality. In fact, these models have been adapted to all types of organizations wanting to improve their products and services.

Quality Improvement Audits For Leaders

This publication is designed to help leaders assess their basic knowledge, behaviors, and attitudes as compared to quality improvement methods used by leading Japanese and American organizations. While it helps the leader take a personal assessment of his or her quality improvement knowledge and behaviors, this audit will also serve as a guide for implementing basic quality improvement behaviors in his or her organization/department.

Taking The Audit

In responding to each of the questions on the audit, be as truthful as possible. Answer how you think things really are, not how they should be. The idea is to take an honest audit of your situation and organization.

After you answer all the questions on the audit, tear off the top sheets and count the correct answers. Indicate the number of correct answers in each category on the bar chart. The results will tell you how you scored in relation to widely accepted quality improvement methods and behaviors.

Quality Improvement Audit For Leaders

Check the answer which you believe to be the most accurate for your present situation.

Attitudes and Beliefs About Quality Improvement

I believe that:	True	False
1. mistakes and defects should be caught during final evaluation or inspection.	____	____
2. problems related to quality are most often the fault of employees, vendors or equipment.	____	____
3. continuous training and education for my staff is vital.	____	____
4. my "gut feeling" is the key to our problem solving.	____	____
5. innovation is the key to quality.	____	____
6. maintaining what we have assures quality.	____	____
7. quality is management's responsibility.	____	____
8. customers or clients define what quality is.	____	____
9. planning and prevention lead to quality.	____	____
10. we must work on everything to increase quality.	____	____
11. we must build in quality.	____	____
12. we must meet deadlines as the way to satisfy customers.	____	____
13. it is always cheaper to do it right the first time.	____	____
14. data and facts should be the basis for decision-making.	____	____
15. we should improve the person responsible or move him/her.	____	____
16. competition between departments is good for quality.	____	____
17. a threat-free environment is best to encourage quality.	____	____
18. work is an art.	____	____
19. I must build partnerships with my staff.	____	____
20. I must develop multiple skills and competencies in my employees.	____	____

Quality Improvement Knowledge

It is my understanding that quality improvement involves:	True	False
1. the idea that everything is a process to be standardized, controlled, and improved.	____	____
2. the standardization of methods as a basis for control and the prerequisite for improvement.	____	____
3. meeting strict production or completion quotas.	____	____
4. the practice of reliable methods in a disciplined way by all.	____	____
5. correcting mistakes as they happen.	____	____
6. the constant measurement of customer or client satisfaction.	____	____
7. a thorough inspection of the end product to control quality.	____	____
8. slogans and goals for employees.	____	____
9. telling the worker only what he needs to know to do his job.	____	____
10. competition between departments.	____	____
11. reducing fear that employees will be blamed.	____	____
12. holding vendors to high quality standards.	____	____
13. adopting a total quality improvement philosophy.	____	____
14. awarding business to the lowest bidders to cut costs.	____	____
15. training employees for specific job skills.	____	____
16. continuously striving to improve products and services.	____	____
17. establishing a clear quality mission for the organization.	____	____
18. the constant use of statistical process control tools to measure quality.	____	____
19. the identification of a vital few problems to improve quality.	____	____
20. a system of teams and employee involvement to solve problems.	____	____

Employee Involvement

My leadership in this organization is characterized by:	True	False
1. providing an on-the-job skills training program.	____	____
2. involving all employees in organizational improvements in quality, cost, and working conditions.	____	____
3. top down management.	____	____
4. working for employee commitment to achieve customer or client satisfaction.	____	____
5. the design of a work environment which meets human needs.	____	____
6. having my top management team establish the system in which employees can produce quality services and products.	____	____
7. setting up a system of teams which involve all employees in quality improvement.	____	____
8. providing self-training manuals to all my employees.	____	____
9. providing a problem-solving process for my employee teams.	____	____
10. instituting a plan, do, check and act team process.	____	____

Quality Improvement Audit For Leaders

Check the answer which you believe to be the most accurate for your present situation.

Attitudes and Beliefs About Quality Improvement

	True	False
1.		QI
2.		QI
3.	QI	
4.		QI
5.		QI
6.	QI	
7.	QI	
8.	QI	
9.	QI	
10.		QI
11.	QI	
12.	QI	
13.	QI	
14.		QI
15.		QI
16.	QI	
17.	QI	
18.	QI	
19.	QI	
20.	QI	

Employee Involvement

My leadership in this organization is characterized by:

	True	False
1. providing an on-the-job skills training program.	QI	
2. involving all employees in organizational improvements in quality, cost, and working conditions.	QI	
3. top down management.		QI
4. working for employee commitment to achieve customer or client satisfaction.	QI	
5. the design of a work environment which meets human needs.	QI	
6. having my top management team establish the system in which employees can produce quality services and products.	QI	
7. setting up a system of teams which involve all employees in quality improvement.	QI	
8. providing self-training manuals to all my employees.		QI
9. providing a problem-solving process for my employee teams.	QI	
10. instituting a plan, do, check and act team process.	QI	

Quality Knowledge

	True	False
1.	QI	
2.		QI
3.	QI	
4.		QI
5.		QI
6.	QI	
7.	QI	
8.	QI	
9.	QI	
10.	QI	

Quality Improvement Audit For Leaders

PART 2

Use of Data

Under my leadership, this organization:	True	False
1. is committed to the need for decisions which are made on the basis of facts and data.	____	____
2. believes that some quality items cannot be measured.	____	____
3. has learned to use statistical process control tools.	____	____
4. involves employees in some type of daily plotting, displaying, and analysis of data.	____	____
5. assumes that facts are correct and are to be used for decision-making.	____	____
6. uses such tools as flow charts, Pareto diagrams, check sheets, and brainstorming.	____	____
7. provides its employees with key performance indicators for major processes.	____	____
8. has established a threat-free culture to support the exchange of data.	____	____
9. has a few key employees who collect the data we need to make effective decisions.	____	____
10. uses data to determine the extent of variability from previously established norms.	____	____
11. uses convergence thinking only.	____	____
12. rewards the quality of ideas employees suggest in team meetings.	____	____
13. uses data to determine where the greatest problems are.	____	____
14. uses a cause-and-effect diagram to solve problems.	____	____
15. uses the Pareto analysis to determine the major few problems.	____	____
16. collects data to be used immediately to facilitate the correction of problems.	____	____
17. uses graphic presentations of data to get a "picture" of the situation.	____	____
18. uses data to prevent over and under adjustment.	____	____
19. uses data to achieve never ending quality improvement.	____	____
20. looks for variation in products or services to determine quality problems.	____	____

My Commitment to Quality Improvement

I have demonstrated my commitment to quality improvement by:	True	False
1. changing my management strategy to quality improvement practices.	____	____
2. converting my top management team to quality improvement principles, methods, and techniques.	____	____
3. focusing training on my top management team.	____	____
4. developing a clear plan for implementing quality improvement with my top management.	____	____
5. committing to purchase a quality improvement book for each of my top managers.	____	____
6. putting quality improvement activities into action.	____	____
7. revising policies to conform to quality improvement procedures.	____	____
8. attending quality improvement training sessions for employees.	____	____
9. working to fix the organization's system which affects quality.	____	____
10. committing to "leaps" in product and service development.	____	____

Personal Leadership Style

My leadership style related to quality improvement includes:	True	False
1. allowing others to express their opinions without fear.	____	____
2. delegating to others according to their ability to do the task.	____	____
3. teaching quality improvement teams how to function before assigning them a problem.	____	____
4. using facts to improve on tried and tested methods instead of launching untested innovations.	____	____
5. pushing the decision-making process about quality down to include even the lowest employee.	____	____
6. providing a feedback system for every employee.	____	____
7. letting others take responsibility for quality improvement while I take care of business.	____	____
8. being attuned to both internal and external customer needs.	____	____
9. being systematic.	____	____
10. stressing teamwork and rewarding it.	____	____
11. praising those who meet production quotas.	____	____
12. providing supervision which helps employees, machines and systems do a better job.	____	____
13. cutting costs related to training and human resource development.	____	____
14. relating my vision of quality improvement to all employees.	____	____
15. focusing on the process, on the team, on the system that will produce long-term quality.	____	____
16. reworking or throwing out defective parts or materials.	____	____
17. listening to our customers.	____	____
18. providing involvement, information, good equipment and tools, and supervisors who care.	____	____
19. communicating to employees why changes are necessary.	____	____
20. believing that most people want to do a good job.	____	____

Quality Improvement Audit For Leaders

PART 2

	True	False
5. committing to purchase a quality improvement book for each of my top managers.		
6. putting quality improvement activities into action.		
7. revising policies to conform to quality improvement procedures.		
8. attending quality improvement training sessions for employees.		
9. working to fix the organization's system which affects quality.		
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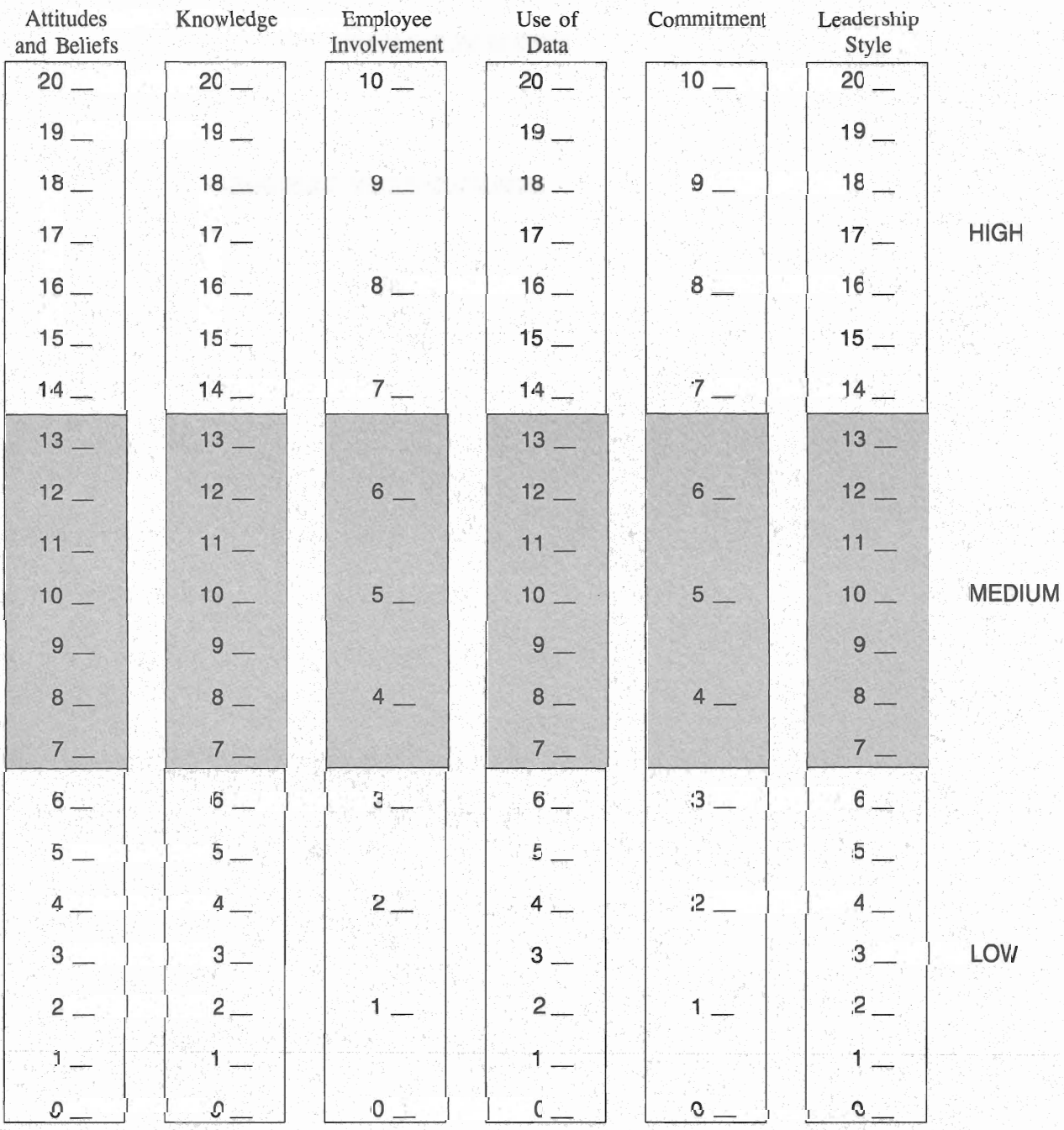
18. providing involvement, information, good equipment and tools, and supervisors who care.		
19. communicating to employees why changes are necessary.		
20. believing that most people want to do a good job.		

Quality Improvement Audit

Bar Chart



Indicate the number correct answers you received on each bar by a dot.
Connect all six dots to determine your profile.

Glossary of Key Quality Improvement Terms

Quality - the features of products and services which meet the needs of customers and consequently provide customer satisfaction.

Customer - Anyone, either external or internal to the organization, who receives or is affected by the product or service itself. This includes the process for making, delivering and servicing the product or service.

Quality policy - An organization's written and communicated statement about its commitment to quality.

Total Quality Management - A system of planning, quality control and quality improvement by teams in an organization in order to deliver products and services at a higher quality and lower relative cost.

Teams - Groups of trained employees involved in problem-solving activities to bring about quality improvement.

Process - A series of behaviors, actions or operations which contribute to an outcome or end.

Prevention - Improving quality by looking at the process itself in order to reduce mistakes from the start.

Problem-solving - A process of identifying causes by analysis of factual and statistical process control techniques.

Statistical Process Control - The use of factual and statistical techniques to analyze a process or its outcomes in order to take action to achieve a state of quality control and to improve the quality of products or services.

Mission - An organization's stated purpose.

Continuous Quality Improvement - A never-ending quality improvement strategy designed to strengthen the organization in the face of present and future circumstances in the world.

ABOUT THE AUTHOR: James H. Brewer is the CEO of Associated Consultants in Education which he founded. He received his doctorate in educational administration and curriculum development. His professional experience spans the fields of public education, private business, writing, video production, higher education, banking, and consulting.

He is the creator of the Power Management System of Leadership and the widely used BEST Instruments. After his twenty years of research in the behavioral sciences, Dr. Brewer has developed many simple but valid tools to help educators, trainers, HRD professionals and leaders increase their effectiveness.

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Appendix G

The [Public] Hospital Mission Statement*

The [Public] Hospital's Board of Governors, Physicians, Support Staff, Auxiliary and Volunteers are committed to the provision of quality care and services and to the management of our resources. Through the process of continuous improvement we will strive to meet the changing individual and collective needs and expectations of patients, community, and staff.

We will:

Provide excellence in Chronic Care and Rehabilitation Services to the residents of [city] and the [locale] Region.

Utilize an interdisciplinary team to identify, plan, implement and evaluate the individual care needs of those entrusted to our care and assist them to function at their optimal level.

Demonstrate a spirit of partnership and mutual respect in all our relationships.

Interact with the community to define our role in the continuum of healthcare.

"Care in Action"

* To honor a commitment to anonymity, the Mission Statement has been retyped, and name and location of the hospital excluded.

Appendix H

Department Manager Question Lines

1. What do you believe is the mission of The Public Hospital?

2. How do you see that mission being demonstrated in behaviors?

3. What do you see as the future direction of The Public Hospital?

4. What will you and your staff require to be prepared to work in health care in the future?

5. What are the unspoken rules in the organization? How do you know that these norms exist?

6. How does one get ahead at the hospital?

7. How do people tend to communicate with each other? How is information moved throughout the organization?

8. Do you receive the information you need? If not, why not? What information would you like that you do not now receive?

9. Who are your heros at the hospital? Why?

10. Are there rituals within the organization? Describe them. What and how does the staff celebrate together?

11. How would you explain the differences in the aggregate scores (OCRS and OCOS) of the Board and those of the managers?

12. What are the values of the hospital as found in the Mission Statement? Do you believe these are the values in action? Explain.

13. If you were to think of the organization as a family, how would you describe family life?

14. Tell me about your experience in your interactions with senior management, especially the Department Head's meeting.

15. Some of your peers have raised the issue of a gender

bias at The Public Hospital? What has your experience been in this regard?

16. How do you know if you're doing a good job? In what way has the organization invested in continuing education or skills development for you?

Board Member Question Lines

1. How would you describe the Mission of The Public Hospital?

2. What course has the Board determined for the future of the hospital?

3. How does the Board enable the hospital to fulfill its Mission?

4. What is the role of the hospital Board?

5. Should the Board retain its present structure and volunteer status?

6. On what criteria does the Board appraise the performance of a CEO?

7. How do you know that the quality of care is considered to be excellent?

8. Can you speak to the experience of staff in their daily worklife?